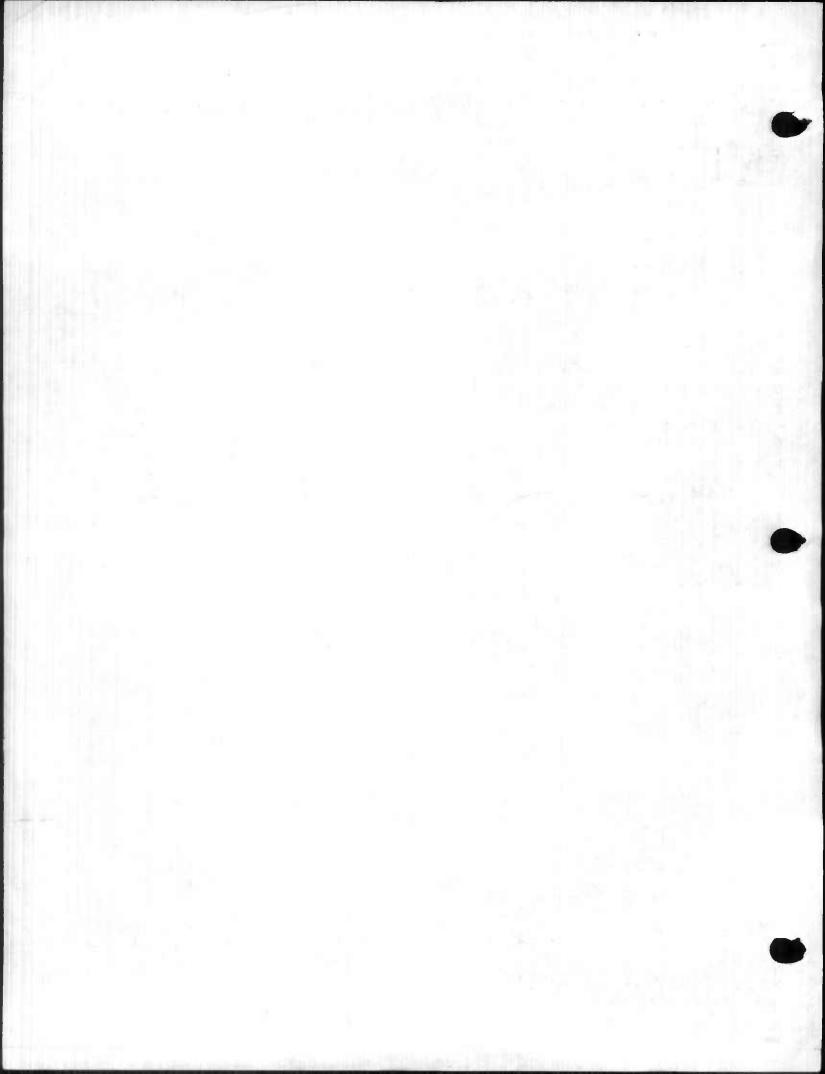
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	Physician /Medical	1. Decedent's Name (First, Middle, L. Alice - T	- 0 4 6 1	EY				A Month	+ Pay	Year 2000	3. Time of Death 4-45 PM	
	Examiner	4a Fscility Neme (If not institution, gi	Control of the second				4b. City, Town, or Lo	ocation of Deeth	4c. County	of Death		
		Howard County Ge			, Y M 64-d-	- 4 V	Columbia If Under 24 Hrs.		Howar			
	Funeral Director		Sex 1□ M 2፟Ø F 7. Age (I	n yrs. lest birt	Months	Days	Hours Min.	8. Date of Bir (Month, De Oct 29	th (Year) 1937		ce (State or Foreign y) ylvania	
pulyland	ahow dat	10a. State 10b. County	10	Oc. City, Town	or Location					10d	I. Inside City Limits 1 Yes 2 No	
2 0	or 28a-1 be notifie Directo	Maryland Howard	I	Ellicot	t City							
h with		10e. Street and Number 2602 Legends Way				Code 042			10g. Citizen of V USA	What Country	77	
020 urs after deat	er, or thems 23 Examiner must by Funeral	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	or in U,S.	13. Wes Dece If Yes, spe		lispanic Origin? (Span, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - American ck, White, etc	c.	
Maryland 21215-0020	ygiene. Ner than *natural, nt, the Medical. Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			Decedent's Use (Give kind of w life. DO NOT	iat Occup ork done ise retire	pation during most of work d)	ing	16b. Kind of B		stry	
P		17. Father's Name (First, Middle, Las		1000	recary		18. Mother's Name	e (First, Middle,				
lan ad be	rhad off rise ever To Be	John Rossi					Louise H	Brill				
ary	T THE	19a. Informant's Name/Retationship	(Type, Print)	19b.	Mailing Address	s (Street	end Number or Run	al Route Numb	er, City or Town,	Stete, Zip C	ode)	
	100	John Paisley / H	usband	260	2 Leger	nds V	Way, Ellic	cott Ci	ty, Mary	land 2	21042	
ore,	other other	20a. Method of Disposition		Date	20c. Location -							
Page Page	T S S	1 M Burial 2 Cremetion 3 M Removel from State 4 Donation 5 Other (Specify) Mtn. View Cemetery 8-17-2000 W. Hazleton, Page 18-17-2000 W. Hazleton, Page 18-17-200 W. Hazleton, Page 18-17-200 W. Hazleton, Page 18-17-200										
Baltimore,	Party and a state of the state	21. Signature of Funerat Service Lige	ensee		Hubbar	d Fu	ess of Fecility eneral Homens Avenue			1	1 21220	
Ph	ysician	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that ceused they one cause on each line.	e death. Do r						- A	Approximate Interval Between Onset and Death	
600000	Medical aminer	Immediate Cause (Final disease or condition resulting in death)			ENAL consequence of		YNDRO	ME			6 malon	
68760, ficate be executed	physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c		consequence of							
X	2 %		d							1		
. 8	ed for	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying	cause giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to t	he cause of death?	
P.O	igned by the attending be detached for use a by Physician/M							10	Yes 20 No	3 Proba	ably 4 Unknown	
Division of Vital Records, or Attending Physician: The lew requires t	should should								an eutopsy ormed?	avail	e autopsy findings lable prior to pletion of cause eath?	
E P	pege 2							10	Yes 2 No	10	Yes 25 No	
ita ::	certificate rector, peg	25. Was case reterred to medicat					26. Place of Deat	h (Check only	one)	- 1-		
of Vita	00	examiner? 1 Yes 2 No	Hospitat: 1 Inpatient	2 ☐ ER/Ou	tpatient 3 D	OA Oth	ner: 4 Nursing Ho	ome 5 Resi	idence 6 Oth	er (Specify)		
Vision o	After funer	27. Manner of Death 1 Matural 5 Pending 2 Accident		ear) 28b. T	ime of njury M	28c. Inju Wo 1 🗆	ry at rk? Yes 2 No	28d. Describe	how injury occur	red		
Divis	s after de	3 Sulcide 6 Could not determined		- At home, fa Specify)	rm, street, facto	ry, office			(Street end Num) wn, State)	oer or Rural i	Route Number,	
- Hospital	within 24 hours after death. To the Funeral Director: After the funeral completely filled in by the funeral Medical Certification:		hysician: To the best of miner: On the basis of ex and manner states	amination and								
Tothe	To the	29b. Signeture end title of certifier	Del -	_		D	se number . 3 è 4 6	٦,	29d. Date signed	ru	+, 2000	
de)		completed cause of deat	h (Item 23a) (Type Print)	1 1	100, Elh	cott cr	ty . M	10 1	21042	
	State Registrar	31. Date fited (Month, Day, Year) AUG 2 2	2000 De See	Signature	15	Spo	rels	100				



Physician /Medical

Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

If Under 1 Year

nor

2

10f. Zip Code

Days

Months

State of Maryland / Department / Ce	artment of Health and <i>rtificate of Death</i>	, ,	. No.	00	26502
onique Poe		2. Date of Death Month August	Day 16	Year 2000	3. Time of Death 02:10 P.M
street and number)	4b. City. Town, o	r Location of Death	4c Cou	nty of Death	

If Under 24 Hrs.

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, atc.)

Baltimore

Date of Birth

N/A

10g. Citizen of What Country?

14. Race -

9. Birthplace (State or Foreigh (Country)

American Indian

Black, White, etc.

10d. Inside City Limits

1. Yes 2 □ No

121

Approximate Interval Between Onset and Death

1 Yes 2□ No

Balt., MD

Scene

Funeral

Director with the Maryland or 28a-f show the Medical Examiner must be notified at 234 death v or items filed within 72 hours after "natural" Hygiene. other

Pages 1 and 2 should be nent of Health and Mental ant: If Itam 27 is marked or Department of Health as Important: If Itam 27 is any injury or other trait

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

Box 68760, The law requires that the death certificate the 28 980 for signed by the a P.O. Division of Vital Records. page this After the

Physician/Medical Examiner p Be Completed To the Hospital or Attending Physician: Medical Certification: To death. after death Director: filled in by within 24 hours a To the Funeral C completely

5. Social Security Number 86 Usual Residence of Decedent 10a. State 10b. County Directo land 10e. Street and Number Funeral 11. Marital Status 1 Never Married 2 ☐ Married þ Be Completed 2 20a. Method of Disposition tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

1. Decedent's Name (First, Middle, Less

4a Facility Name (If not institution, giva

441

6. Sex

East Eager Street

1 M 2 KF

12.

7. Age (In yrs. last birthday)

Yrs

10c. City, Town or Location

Was Decedent Evar in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Datas: 1 Yes 20 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation
(Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary(Secondary (0-12) College (1-4or 5+) 17 Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) (Mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place 1 ⊠ Burial 2 □ Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) emeter 21. Signature of Funeral Service License 22. Name and Address of Facility, Joseph 2222 U era NOr tue 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. HANGING Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of causa ot death? 24e. Wes an autopsy performed? Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Nother (Specify) 1M Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of (fand) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1:45 PM 2 No 8/16/00 1 Yes 2 Accident 3 Suicide Subject hanged self 28f. Location (Street end Number or Rural Route Number, City or Town, State) Women Detention Ctr. 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

> 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. August 17, 2000

441 E. Eager St.

who completed ceuse of death (Item 23a) (Type, Print) 30. Name and address of person

111 Penn Street, Baltimore, Maryland 21201 Tirus M.1)

JACK M. 31. Date filed (Month, Day, Year) State Registrar

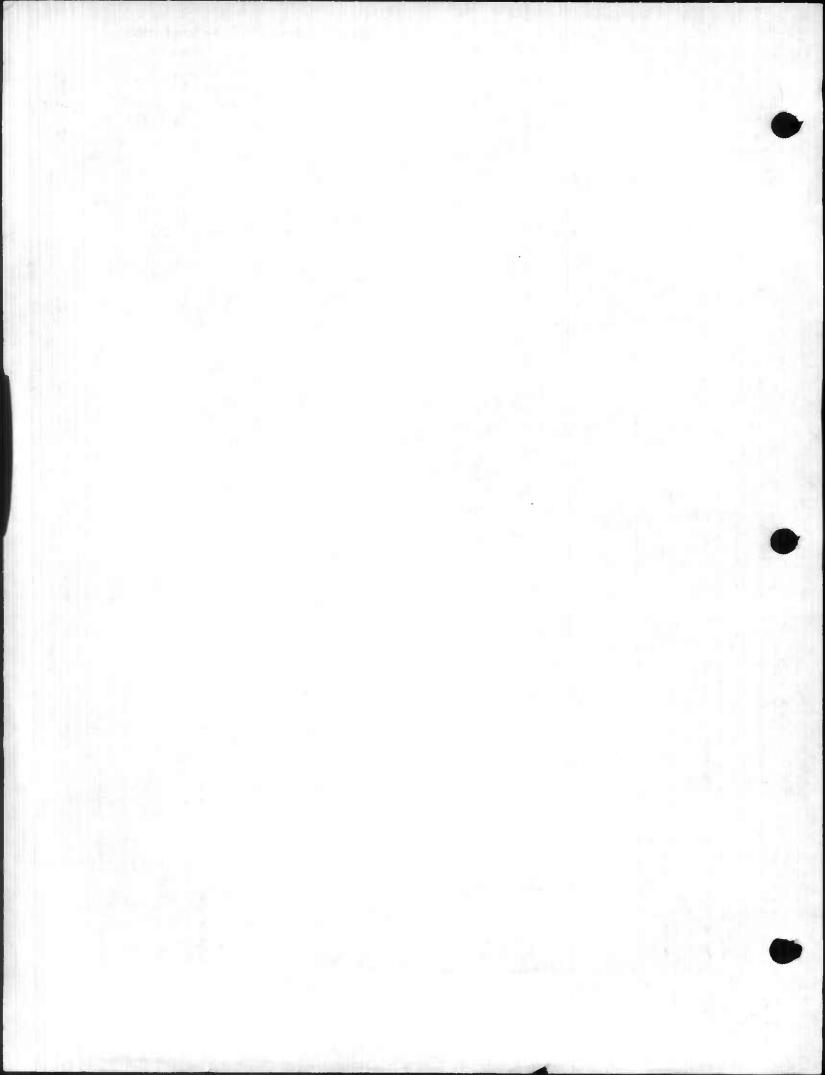
29b. Signature and title of certified

4 Homicide

29e. Cartifier

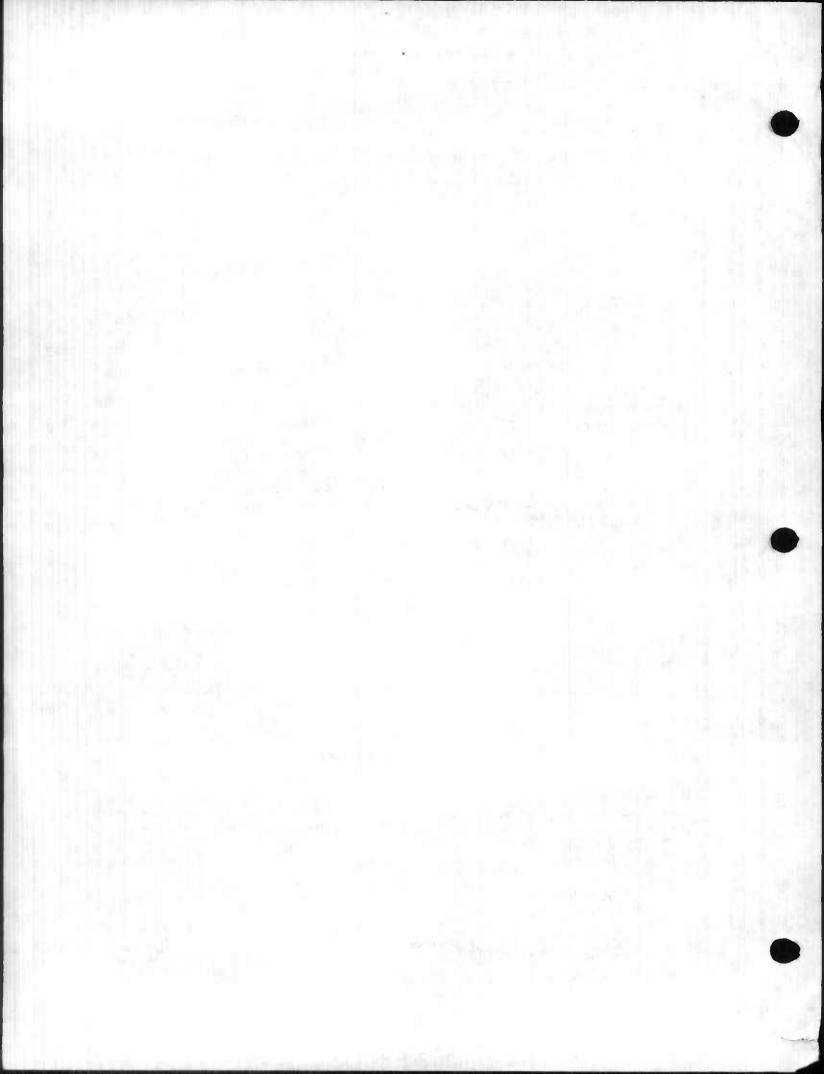
32. Registrar's Signature

Cell



State of Maryland / Department of Health and Mental Hygiene 00 26503

			Ce	rtificat	e of	Death			Reg. No.			000	
	1. Decedent's Name (First, Middle, Las	()						2. Date of Dea	ath		3. Time	of Death	
Physician	John R	ussell Payı	ne				251	AMGUS	Day	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	5:0	ID AM	
/Medical Examiner	4e Facility Name (If not institution, give Saint Joseph	street and number)				4b. City, To	own, or Lo	ocation of Death	4c. County	of Death Balt	imor	· e	
Funeral Director	5. Social Security Number 6. Se 216-05-3237	7. Age ((In yrs. lest birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Dete of Birth (Month, Dey, Year) 5-5-1916		9. Birthpl Count Max	ace (State ry) ylan	e o <i>r Foreig</i> n	
	Usual Residence of Decedent										2		
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her das her das her ma funer	11. Marital Status 1 Nevar Married 2 Married MUWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? Y Yes String If Yes, Give Year or Dates:	er In U,S. 13.		Y P	Hispanic Ortoan, Mexicen		ecify Yes or No- Ricen, etc.)	14. Rec Bla Specifi	e - America ck, White, e White			
72 hg	15. Decedent's Edi (Specify only highest grad	ucetion	16a. Dece	dent's Usu	et Occu	pation	t of worki	ina	16b. Kind of B	usiness/Ind	ustry		
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antal Hygersel of the control of the	17. Father's Neme (First, Middle, Last) Raymond	L. Payne			1		er's Neme	(First, Middle,	Maiden Sumen	ne)			
TO DE P	19a. Informent's Name/Relationship (T		19h Malti	na Address	: (Stree				er, City or Town,	State Zin	Code)		
nd 2 selfth ac 27 is or theu	Mrs Barbara S. Ho								ister,			21157	
Hann State of State o	20a. Method of Disposition	Illett (LITE	20b. Place of Dispo	sition (Ner	ne of			Date	20c. Location				
mit. Pages 1 a partment of Hei portant; if item y injury or othe ce.	1 Buriel X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22 Name and Address of Excility												
Depar Impor Impor any in	21. Signeture of Funarel Service Licensee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204												
S III III	23a. Pert1. Enter the disease, or comp shock, or heert faiture. List only of	tications that caused th	ne death. Do not en							1	Approxin	nate	
Physician / /Medical	Immediate Cause (Final disease or condition		ENIC SH	OCK							Onsat an	OURS	
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The is the page page								101	Yes 25 No	10	Yes 2	No No	
rector, page 2	25. Was case referred to medicet					26. Place	e of Death	h (Check only o	-				
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Attending Physician: ordeath. ector: After this certific by the funeral director, Ification: To Be (27. Menner of Deeth 11S Natural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Dey)			28c. Inju				now injury occur				
Later or Attending Physician: The state death. In Director: After this cardificate led in by the funeral director, particularity. Certification: To Be Co	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc.	/ - At home, farm, st (Specify)	reet, factor	y, office			28f. Location (S City or Tox	Street end Num. vn, Stete)	ber or Rure	l Route N	lumber,	
To the Hospital or Attends within 24 hours after death. To the Funeral Director: A completaly filled in by the fu	29e. Certifier (Check only one) 2 Medical Exam	raician: To the best of a liner: On the basis of ea and manner state	xaminetion end/or In	h occurred	at the t	ime, dete ar opinion, dee	nd plece, o	end due to the ed et the time,	cause(s) and m date end ptace,	enner as st and due to	ated. the caus	ee(s)	
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02-1041	30. Name and address of person who o	ompleted cause of das	th (Item 23e) (Type, 1 OSLER	Print) DRI	JΕ,	TOWS	SON,	MARYL	AND E	21204			
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State of Maryland / Department of Health and Mental Hygiene

Ce	rtifica	te o	f De	ath

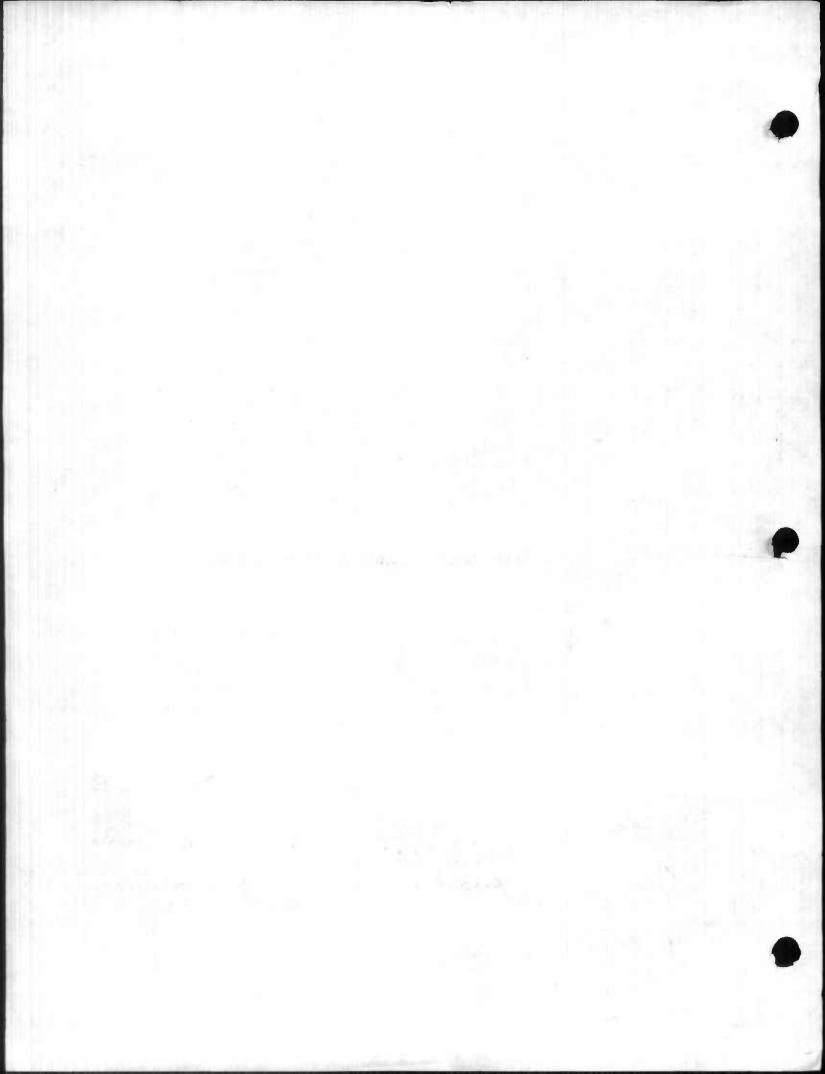
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	208	a. Method of Dis	•				p. Place of D	isposition (Na crematory or	me of other place	ce)		Date	20c. Loca	tion - (City or Tow	n, State	
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infur.				-													
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DHMH 16 Rev 6/95

State

Registrar

AUG 2 2 2000 ----



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month MI ChAEL ALLEN FA. 4e. Fecility Neme (If not institution, give street end number) RUGOST 1227AM 2000 4b. City, Town, or Location of Deeth 4c. County of Deeth HOSB, TALCONTER NORTH WEST DALTIMORE RANCAIISTOWN If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day. 6. Sex 128 M 2□ F If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) NEW W.V. Months Deys Hours Yrs 235-04-4551 Nov.30,1971 Martinsville Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ No Reistertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Butler Road 21136 USA 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 Engineer Health Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Bert Allen Priest Emma Melissa Loy 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joyce Schab Wife 409 Butler Rd. Reistertown MD 21136 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete New MARTINSVIILE 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 8-21-00 4 ☐ Donetion 5 ☐ Other (Specify) Greenlawn Mem. Park W.V. Euneral Servica Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Hame, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or hear feilure. List only one ceuse on each line. Approximete Onset end Deeth Immediate Cause (Final · MUCCARDIAL FAILURE disease or condition resulting in death) GENITAL HEART DISEASE Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or es e consequence of) Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exempler? 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

1 1 Yes 2 No

5 Pending Investigation

6 Could not be

27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifier

29b, Signatulle

4 ☐ Homicide

31. Dete filed (Month, Day, Year) AUG 2 2 2000

permit. Page Department of Important: If any injury or once. = 6

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be 20

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

with

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

nt: if Item 27 is marked other than "natural", or Items 23.

7 is marked other than traumatic event. In Me

other t

altimore, Maryland 21215-0020

physician end s the buriel-trans page 2 should peen

requires that the death certificate be exec signed by the a certificate After this death.

P.O. Box 68760. Division of Vital or Attend after death Director: filled in by the To the Hospital or within 24 hours aff To the Funeral Di completely filled in

State Registrar 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as stated.

I Medicat Exeminar: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

28c. Injury et Work?

1 Yes 2 No

deeth (Item 23e) (Type, Print)

28e. Date of injury (Month, Dey Year)

30. Name p

0 32. Registrer's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

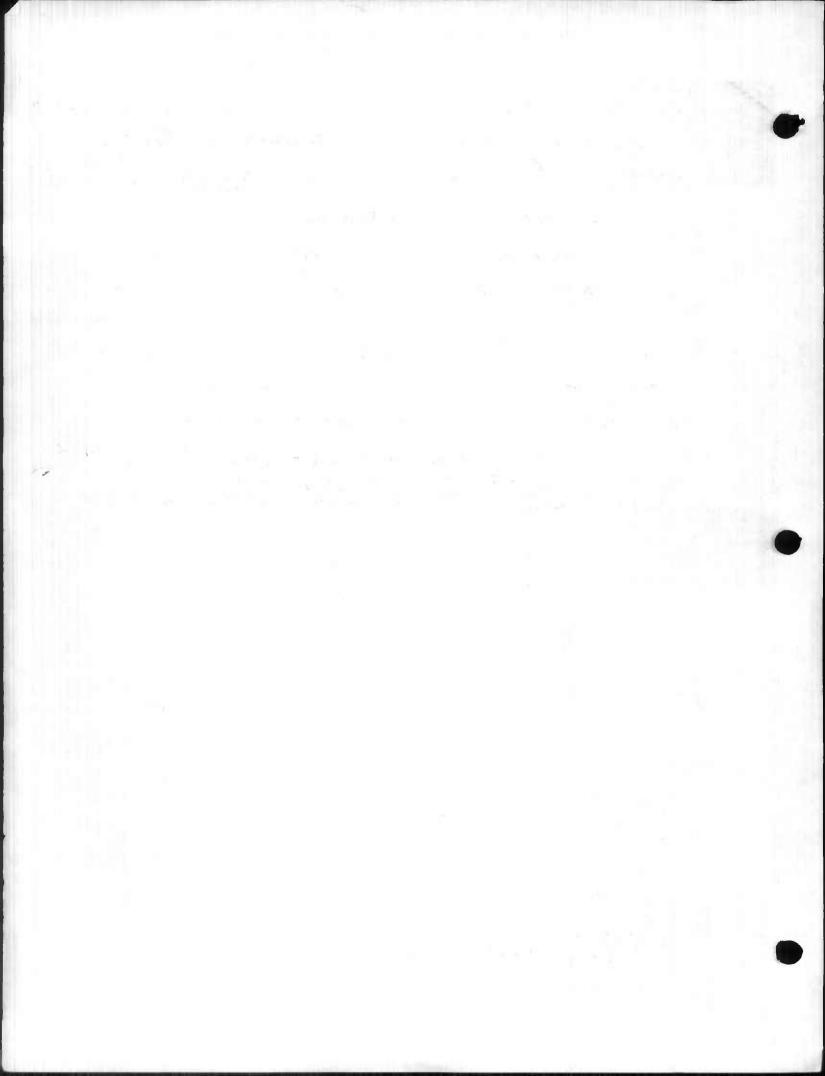
28b. Time of

FREDERICK AVE CATONSVILLE 21228
MARGEANS

28f. Location (Street and Number or Rural Route Number, City or Town, State)

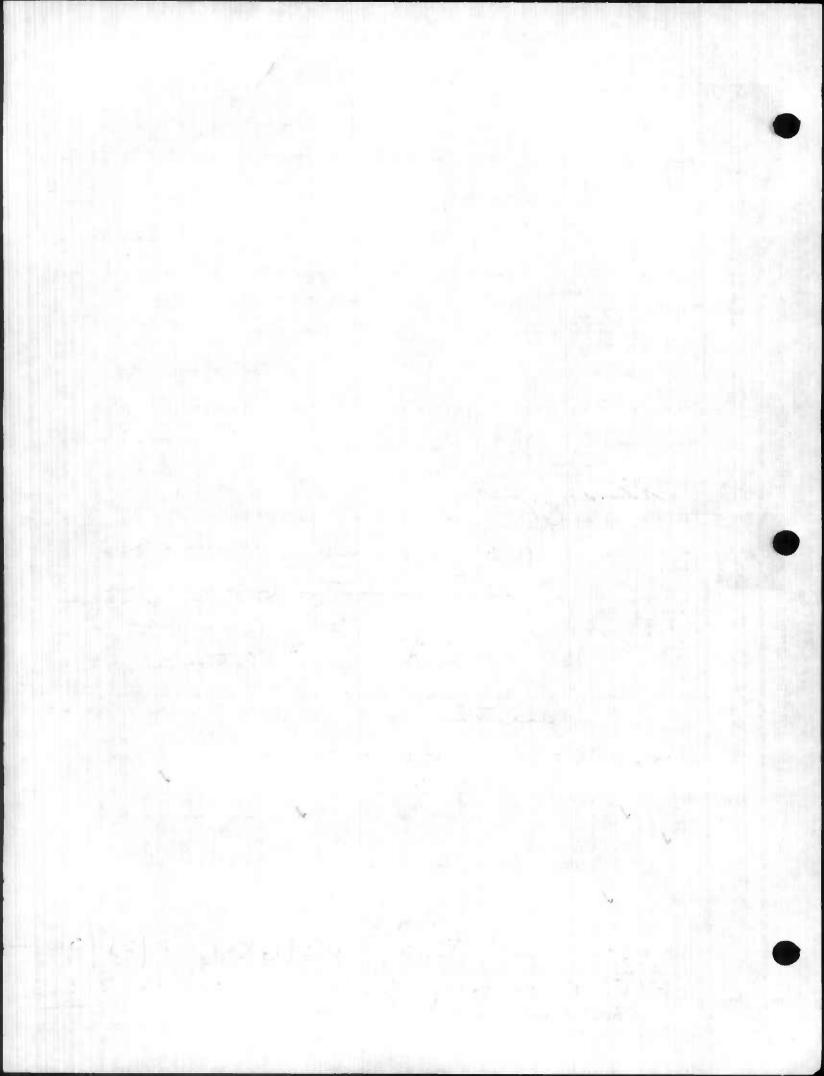
Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

28d. Describe how injury occurred



State of Maryland / Department of Health and Mental Hygiene 00 26506

	Certificate of Death	Re	ig. No.	20000	
Dhysisian	Decedent'a Name (First, Middle, Last)	2. Data of Death Month	David Maria	3. Time of Death	
Physician /Medical	Mazie V. Peake	August	18, 2000 2000 18 18 18 18 18 18 18 18 18 18 18 18 18	3:45 A	
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Death	4c. County of Deat	h	
Funeral Director	Forest Haven Nursing Home Catonsv: 5. Social Security Number 6. Sex $1 \square M$ 2 $\overline{\mathbb{R}}^F$ 7. Aga (In yrs. last birthday) $\overline{\mathbb{R}}^F$ $\overline{\mathbb{R}^F}$ $\overline{\mathbb{R}}^F$ $\overline{\mathbb{R}^F}$ $\overline{\mathbb{R}}^F$ \mathbb	8. Date of Birth (Month, Day,		more holaca (State or Forei untry) ginia	
2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Li			
ahow ad at				1 ☐ Yes 3/☐ I	
be notified Director	Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code	14/	41		
Lbe notified at			0g. Citizen of What Co	untry	
ms 23 cmust		pority Yes or No-	USA 14. Race - Ame	rican Indian	
Examine must	11. Maritat Status 1 □ Naver Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Evar in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerform Yes, Give Year or Dates:	o Rican, etc.)	Black, White		
ygiene. Net then "neturel", or lie nt, the Medical Exercites Completed by Fu	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kind of Business/	Industry	
# 5	Elementary/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)				
Hygiene. ther then ent, the Me	6 Dietician Aid		State Hosp	ital	
Be soft		ne (First, Middle, M	Aaiden Sumeme)		
Men tic	Daniel Fleming Childress Ora Tayl				
_ = =	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Ru			(ip Code)	
Department of Heelitt Important: If Item 27 eny injury or other to page.	20a. Method of Disposition 1	8-22-00 ome	eóc. Location · City or Marriottsv	rille, MD	
	Edward A. Greechik 301 Frederick Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	1 Catons	ville, MD	21228 Approximate	
the has been signed by the ettending physician and page 2 should be detached for use as the burial-transit and completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of):	0000	roso		
the ett hed fo	Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld to	bacco uae contribute	to the cause of dea	
ed by the ettendidetached for use	7-1.0.0:	1 🗆 Ye	8 2 No 3 P	robably 4 9 thkn	
page 2 should be de Completed by P	Hypertaine Colinarile	24a. Was a perform	med?	Were sutopsy findin- available prior to completion of cause of death?	
	25. Was case referred to medical 26. Place of Dec	1 🗆 Ye		1 ☐ Yes 2 ☐ No	
s certific director,	axaminer? Hospital:	eth (Check only on	ence 6 Othar (Spe	nife il	
h. After thi funeral tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 2 Accident invastigation 28a. Date of Injury (Month, Day Year) 4 Natural 1 Yes 2 No	28d. Describe ho	ow injury occurred		
Series after	3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town			
n 24 hours he Funeral pletely filled edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred and manner stated.	, and due to the ca rred at the time, de	ause(s) and manner as ete and placa, and due	s stated. e to the cause(s)	
within To the comple	29b. Signature and title of cartifler B 29c Licensa number.	80 2	9d. Date signed (Mont	h, Day, Year)	
X	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	e Be	el-bo.	21219	
State Registrar	31. Date filed (Month Par Year) 2 2000 Propular Sonate & Sparks				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			Certificate of I			eg. No.	26507
			1. Decedent's Name (First, Middle, Last)		2. Date of Dear	th	3. Time of Death
0.	Physicia: /Medica	_	Helen Agnes Rafferty	/	Month	Day Year 19 200	- 1
	Examine			4b. City, Town, or Loca		4c. County of De	
				Baltimor		N/A	
	Puneral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days	H Under 24 Hrs. 8 Hours Min.	B. Dete of Birth (Month, Day Sept	7,1904 M	inthplace (State or Foreign Country) aryland
	pung Man	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary Hed at	ğ	Maryland Baltimore White Hall				1 ☐ Yes 🎾 No
	iff with the Maryt 23e or 28e-f sho ust be notified at	al Direc	10e. Street and Number 10f. Zip Code 2411 Garrett Road 2	1161	1	Og. Citizen of What G	
5-0020	urs after deal af, or harms 2 Examiner mu	by Funer	11. Maritat Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Ar Black, Wi Specify: W	
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done of the completed] [Give kind of work done of the completed]	eation during most of working		16b. Kind of Busines	ss/Industry
12	100	npie	Elementary/Secondary (0-12) College (1-4or 5+)				
7	Mar di	3	10 Secretar 17. Father's Name (First, Middle, Last)	18. Mother's Name (Circl Middle		l Motors
and	ad be dod	o Be	Joseph Francis Althoff	Elle		thes	
7	though mark mark	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				. Zip Codeh 1 1 C 1
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e,	Mem other	1	20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	ce)	Date	20c. Location - City	or Town, Stete
E	Page Intent		1 □ Burial 2 ☑ Cremetion 3 □ Removel from State 4 □ Donation ○ 5 □ Other (Specify) Chesapeake Cre		/21/00) Beltsv	ille, MD.
atti	mut. ports y inju		21 Signature Funeral Service Licensee 22. Name and Address	ess of Facility			21211
00	28228		Burgee-H	lenss-Sei	tz Fur	neral Ho	me, Inc.
			Burgee-H 3631 Fa1 20a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying shock or hart failure. List only one cause on each line.	ng, such as cardiac or	respiratory arr	est,	Approximate interval Between
3	Physician			1			Onset and Death
	/Medical Examiner		tmmediate Cause (Final disease or condition resulting In death) a.	entension	·		5 years
L		Jer	Due to (or as a consequence of): Cugestre her	+ Snilve	•		1 year
	ate be executed thysician and the burial-transit	Examiner		1	Van 18	District Control	
90,	cate be execut physician and s the burial-tra-		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	tenia			2 m-12
68760,		dicai	that initiated events resulting in death) Last Due to (or as a consequence of):				
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0	the sich sich	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	236. Did to		Probably 4 Unknown
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Records	lew requires that as been signed b 2 should be deta	Completed	Hypenatiema secundary &	druesis	24a. Was a perfor		b. Were autopsy findings available prior to completion of cause of death?
A.	The lev ate has page 2	E			1 U Y	es 2 No	1 Yes 2 No
Vital	ysician: The	200	25. Was case reterred to medical examiner?	26. Place of Death	(Check only or	ne)	
of V	2 00	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Oth	4 Li Nursing Home	e 5 🗆 Resid	ence 6 Other (S	pecify)
	tending Ph leath. for: After th the funeral	Certification:	27. Manner of Death 1 □ Naturat 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Wor		3d. Describe h	ow injury occurred	
Division	Attending or death. ector: After by the fune	Car	2 Accident	Yes 2□No	M Location /S	Street and Number of	Rural Route Number,
≥ D	affer A in by	ELE	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Tow		, , , , , , , , , , , , , , , , , , , ,
	apita neral		29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tin	me, date and place, ar	nd due to the c	ause(s) and manner	as stated.
		edical	(Check only one) 2	pinion, death occurred	d at the time, o	date and place, and o	lue to the cause(s)
	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	E	29b. Signeture and 10h of certifier 29c. Licens	ie number	1	29d. Date signed (Mo	
	1		1//re 1)	5890	1	Hugust	-19,2000
	19		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	hr- 1	Nema	(H.	ital
	State	3	31. Date filed (Month, Day, Year) 32. Registrar's Signature & Spark	4		1	
	Registra	r	AUG 2 2 2000 Seneral 19 190000				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Dey 2000 AUG **Physician** 19 ROTHBARD 7:30AM LEE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Deeth Examiner PIKESVILLE NURSING & CONVALESCENT CENTER PIKESVILLE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. JAN 26 1908 5. Sociel Security Number 9. Birthplaca (Steta or Foraign **Funeral** 1□ M 2♥ F ROMANIA 167-20-2096 Director Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits BALTIMORE ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at PIKESVILLE 1 ☐ Yes XX No Director 10a. Streef and Number 10f. Zip Code 10g. Citizen of What Country? death Funeral 7 SUDBROOK LANE 21208 USA 12. Wes Decedenf Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whifa, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mentel Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify WHITE p 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) BOOKKEEPER ELECTRICAL SUPPLY CO. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be **JOSEPH** GOLDSTEIN YETTA ROSENFELD To 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth as Important: if Itam 27 is any injury or other training. MRS.MARILYN LEIBOWITZ/DAUGHTER 10850 GREEN MOUNTAIN CIR. #305, COLUMBIA, MD. 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation Temovel from State
4 Donation 5 Other (Specify) 8/21/00 TREVOSE, PA. ROOSEVELT MEMORIAL PARK 22. Name end Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart tellure. List only one cause on each line. 21208 Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 1 Par Examiner Due to (or as a consequence of) Examine physicien and s the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical Dua to (or es a consequence of) 88 attending Box USB P.O. 23b. Did tobacco use contributs to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. the signed by 1 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? has page 1 Yas 2 No 1 ☐ Yes 2 ☐ No this certificata of Vital To the Hospital or Attending Physician: within 24 hours after death.

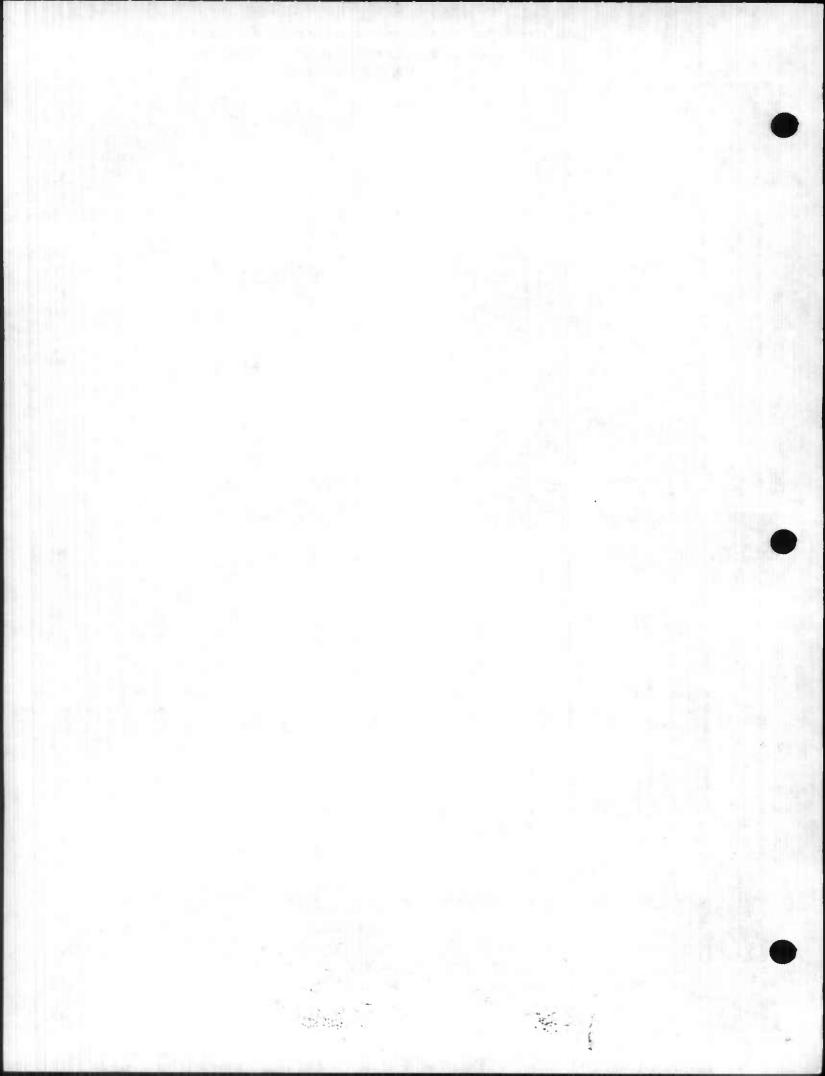
To the Funeral Director: After this certified completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpetient 3 DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 27. Menner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Neturel Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury · Af homa, farm, sfraaf, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 737573 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Horghits Park Battimore MD ZIZO8 Nedis MD 7220 31. Dafe filed (Mont) 32. Registrer's Signatura State

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Registrar

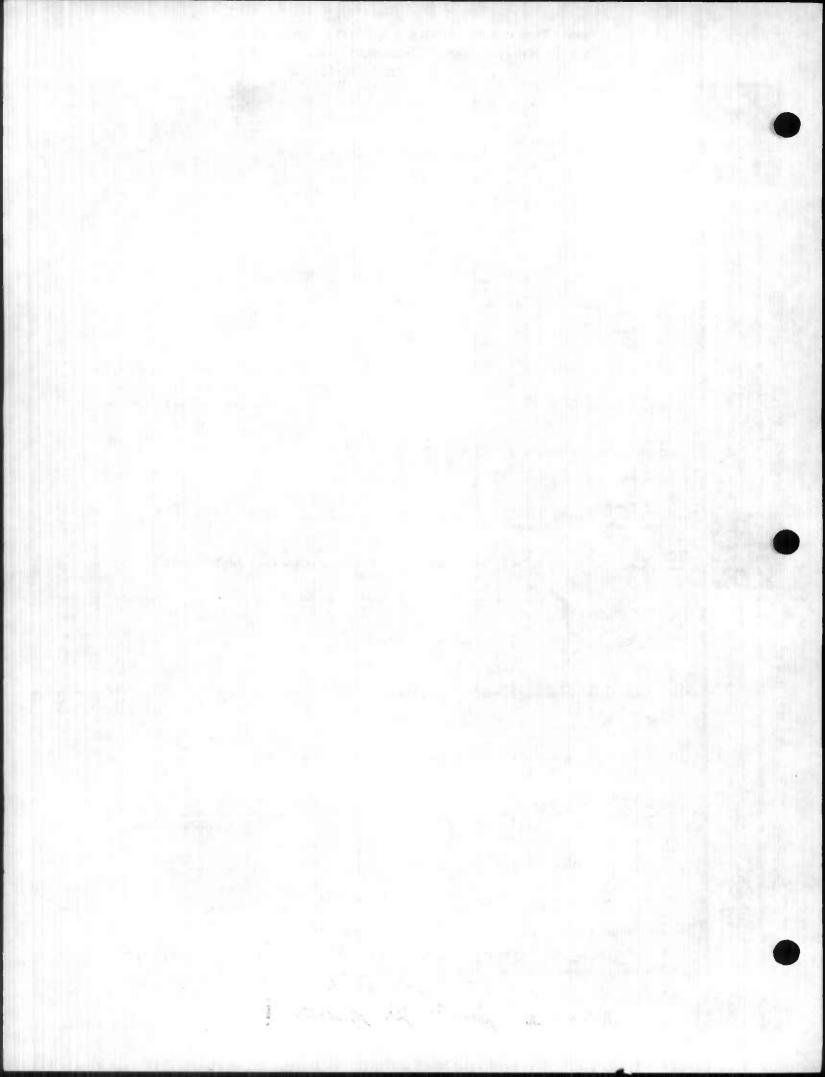
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State of Maryland / Department of Health and Mental Hygiene

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		Ce	rtificate of	Death	R	eg. No.	0 20000						
	Decedent's Neme (First, Middle, Last)				2. Date of Dea Month	th Day	3. Time of Death						
Physician /Medical	Francis J. Sasada					18, 200	8:30 AM						
Examiner	4a Facility Name (If not institution, giva street and numb	per)		4b. City, Town, or	Location of Death	4c. County	of Death						
	Good Samaritan Hospita	1		Baltimore		N/A	THE RESERVE						
Funeral	1 Thu and a	. Age (In yrs. last birthday)	Months Day		8. Date of Birth (Month, Pay Aug. 4,	Year	Birthplace (State or Foreign Country)						
Director	216-30-7331	68 Yrs.			Aug. 4,	1932	lary land						
2 .	Usual Residenca of Decedent 10e. Stata 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits						
aryta asho adas							1 No 2 No .						
with the Marylan a or 28a-f show Lbs. notified at Director	MD N/A 10e. Street and Number	Baltimo	10f. Zip Code		1	0g. Citizan of W							
D Be in				1.4									
e 23	6406 Fair Oaks Avenue	ant Ever in 11 C 12	212		pecify Vas or No-	U.S.A.	- American Indian,						
Maryland 21215-0020 62 should be flied within 72 hours after death v th and Meretal Hyghere. 7 te merised other than 'natural', or Hems 23a treumstic event, the Medical Examiner must To Be Completed by Funeral	1 Navar Married 2 Married 1 X sa 2 Married 3 Widowed 4 Divorced 1 X sa c or Date Year or Date	□ No	II Yes, specify Cu	Hispanic Origin? (S ben, Mexicen, Puer Specify:	to Rican, etc.)		k, White, etc.						
S-0 2 70 2 70 Ted	15. Decedenl's Education	16a. Dece	edent's Usual Occi	upation a during most of wo	rking	16b. Kind of Bu	siness/Industry						
nd 21215-0 be flied within 72 ho hit Hygiene. I other than 'natur went, the Medical.	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4)	lor 5+)	DO NOT use retir	ed)	King .								
21 Parent	10		Manager			Produce	9						
De digital	17. Father's Name (First, Middle, Last)				me (First, Middle,		θ)						
aryland S thould be field in Mertal Hyg marked other marks event, To Be C	Frank Sasada			Mary E	lizabeth	Banz							
faryla 2 should and Mer is ments summits	19a. Informant's Name/Relationship (Type, Print)			et and Number or Ri									
	Marie Sasada- Spouse			ks Avenue			yland 21214						
altimore, mit. Pages 1 as partment of Hea portant if Hear y Injury or other 58.	20a. Mathod of Disposition 1 1 Burial 2 □ Cremation 3 □ Ramoval from St	20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	(ece)	Date	20c. Location -	City or Town, State						
E dans	4 Donation 5 Other (Specify)	Parkwood	Cemeter				re, Maryland						
Saltin emit. Pa epartmen montanti ny injury nose	21. Signature of Funeral Servica Licansee	2	2. Nama and Add	ress of Facility Le	onard J.	Ruck, In	nc.						
O 89128	21. Signature of Funeral Servica Licansee 22. Nama and Address of Facility Leonard J.Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214												
	23a. Part1. Enter the diseese, or complications that cau shock, or heart failure. List only one cause on each	used the death. Do not er	nter the mode of d	ying, such as cardia	c or respiretory arr	est,	Approximete Interval Between						
rdificate be executed ing physician and as the burial-transit Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	Due to (or as a conse	equenca of):	VASCULAR	ARO	Aser							
Me ass	rasulting in death) Last	Dua to (or as a conse	quence of):										
O. I of the state	Part II. Other significant conditions contributing to dea	th but not resulting in tha	undarlying cause	given in Part I.	23b. Did to	obacco uss cor	ntribute to the cause of death?						
P.O. do by the detacher					101	es 2 No	3 □ Probably 4 ☐ Unknown						
Cord requir been s should					24e. Wes a perfor	n autopsy med?	24b. Were autopsy findings available prior to completion ol cause of death?						
Re lev lev lev lev lev lev lev lev lev le					10 Y	es 2 No	1 □ Yes 2 □ No						
f Vital Re veiclen: The second director, page	25. Was case referred to medical			26 Place of De	ath (Check only or	- (18100 2810						
Of VIta Physician: this certificant director.	examiner? 1 Yas 2 No Hospitel: 1 Ing	patient 2 ER/Outpatie	ent 3D DOA	Wher:	dome 5□ Rasid		er (Specify)						
Phys oral d	27. Manner of Death 28a. Date of (Month,				28d. Describe h								
Ion offing Parties : After a funer	1 Naturet 5 Pending (Month) 2 Accident Investigation	Dey Year) Injury		onk? □Yes 2□No									
Division or Attending after death. Director: After Lin by the fune	3 Suicide 6 Could not be	Injury - At home, larm, s	treet, factory, offic	0	28I. Location (S	treet and Numb	er or Rural Route Number,						
Div after dinby	4 Homicide building	, etc. (Specity)			City or Tow	n, Stele)							
Divi	29a. Certifier (Check only one) 2 Medical Examiner: On the base and manner	is of examinetion and/or la											
within To the Comp	29b. Signature and title of certifier	Sherk	29c. Lice	> 2533	/	8/21	Month, Day, Year)						
P	30. Nama and addrass of person who completed cause 2360 W. SORDA	of death (Item 23a) (Type	Print) ER	e FISH	CR MA 2109	3.							
State	31. Data liled (Month, Day, Year) 32. Reg	gistrar's Signature	4 1	1									
Registrar	AUG 2.2 2600	Dene.	1. 600	us i			1						



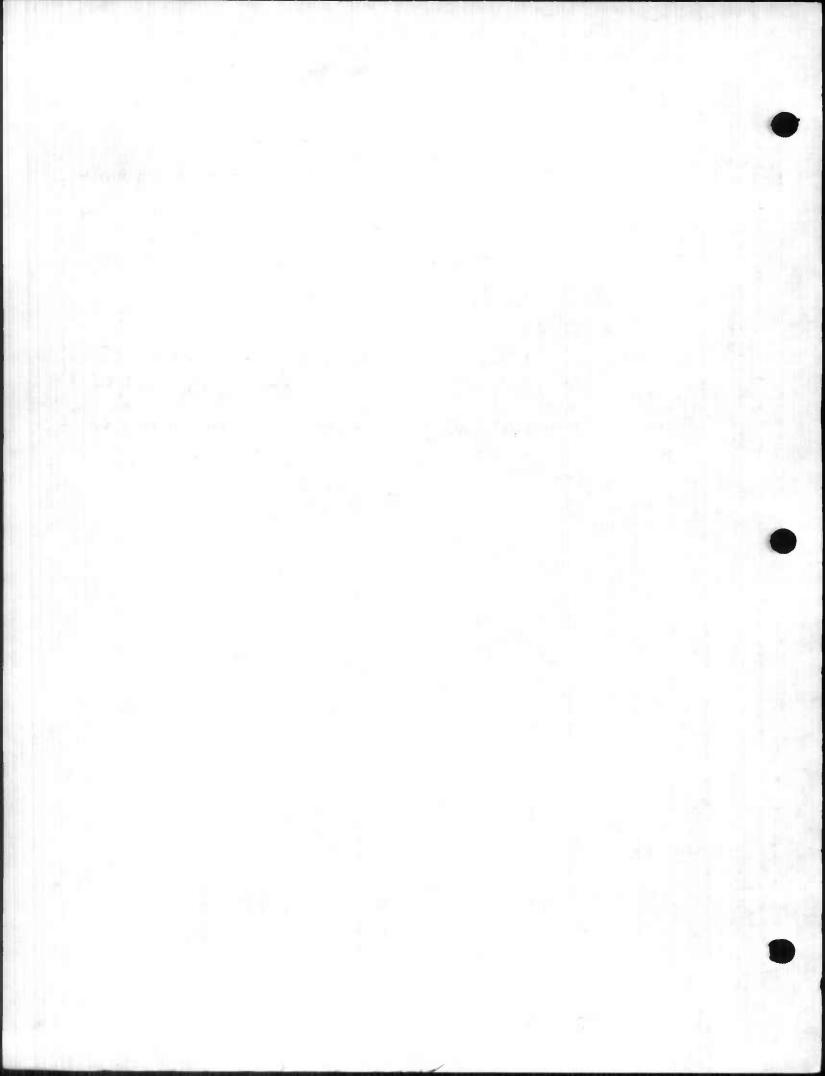
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32. Registrar's Signeture



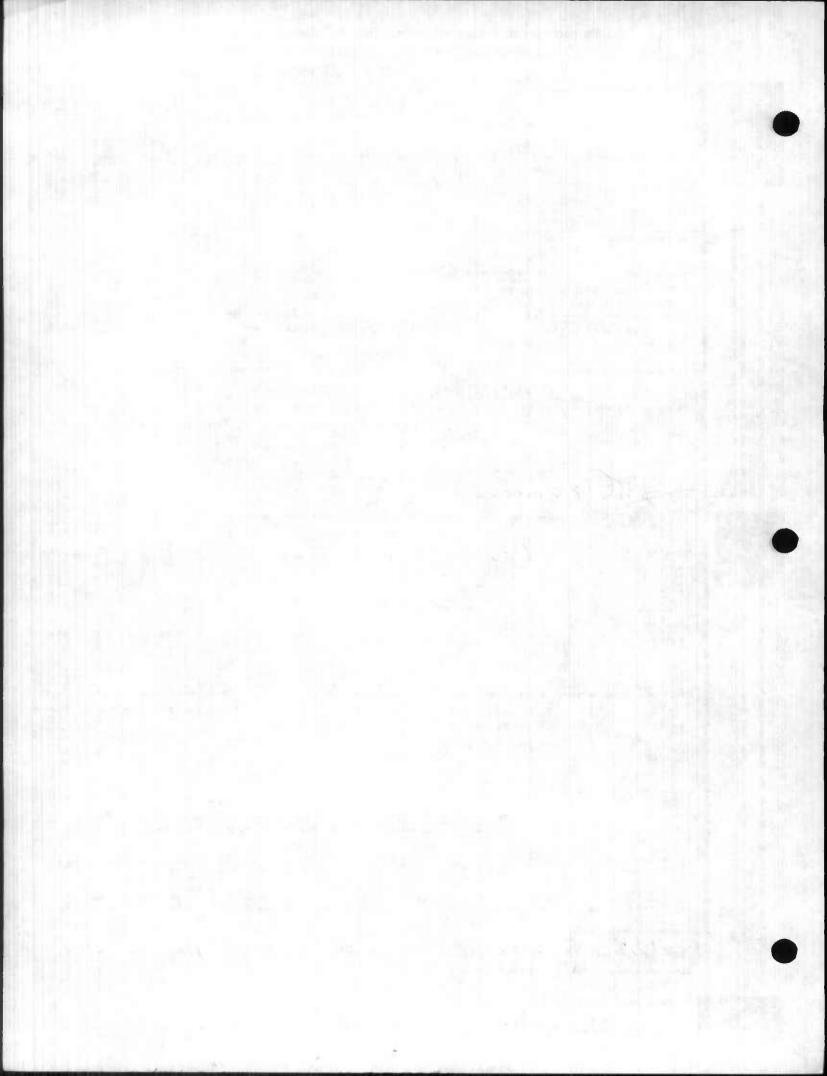
State of Maryland / Department of Health and Mental Hygiene

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					Certificat	e of	Death		F	Reg. No.	00	20.	011
		1. Decedent's Name (First, Middle, I	ast)		Ne l'Illian				2. Date of Dec		Vaar	3. Time	of Death
Physic		Robert	Bruce		Seim				Month August	Day 19,	2000	11:1	ZAM
/Medi Examir	-	4e Facility Name (# not institution, g			5024		4b. City, To	wn, or Lo	cation of Death		inty of Deet		2 1
Examin	ier	Greater Baltimo					Tows	n		R	altim	ore	
-				ge (In yrs. last bir	thday) If Unde	r 1 Yeer			8. Dete of Birt				e or Foreign
Funeral Director		215-07-8169	1⊠M 2□F		Yrs. Months	Deys	Hours	Min.	8. Dete of Birt (Month, Da) Dec 11			untry) rvlanc	te or Foreign
		Usual Residence of Decedent		01					Dec 11,	1910	Fla	Гутанс	1
yland		10a. State 10b. County		10c. City, Town	n or Location							10d. Inside	City Limits
/arylan f ehow	0	Maryland Baltin	nore	Cov	ckeysvil	10						1 🗆 Y	es 2 No
the M	Director	10e. Street and Number	MOTE	001	10f. Zij					10g. Citizen	of What Co	untry?	
- 5 δ €	ā				101. 23		000					,	
ath w	erai	10313 G Malcolm		. Francis III C	40 Wes Deep		030	-1-2 (0-	noife. Van an Na	USA		rican Indian	
er des	Funeral	11. Meritel Status	12. Wes Deceden Armed Forces	7	if Yes, spe	city Cub	an, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, White		
	by F	1 Never Merried 2 Merried	If Yes, Give	INO	1 ☐ Yes	2₩ No	Specify:			Spe	ecity:		
Oo uno		3 Widowed 4 Divorced	Year or Dates	1777 70	1					400 100 1		ilte	
72 22	Completed	15. Decedent's (Specify only highest of	Educetion rade completed)	16a.	(Give kind of wo	ork done	during mos	t of work	ing	16b. Kind o	/ Business/	Industry	
vithin within them them	g	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT u					C		tions	
offine the	ပ္ပ	12	n/a		Foreman	1/ Su	1		40° - 1 0 0 1 1 1 1 1		unica	LIONS	
be file dothe	Be	17. Father's Name (First, Middle, La		300					e (First, Middle,				~
ylan ould be Mental arked o	10	Robert W:	illiam	Seim			At	nnie		Janice		Cos	fer
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Pyglene. The marked other than "natural", or traumatic event, in Medical Estimation		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Addres	s (Stree	t end Numb	er or Run	el Route Numbe	r, City or To	wn, State, 2	Zip Code)	
CENL		Ruth W. Seim/Wi:	fe		10313 G	Mal	colm (Circ.	le, Cocl	keysvi	11e,	MD 2	1030
The Hand		20a. Method of Disposition		comoto	Disposition (Nery, cremetory or	me of other ple	ice)	1	Date	20c. Location	on - City or	Town, State	
Page 1	9	1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special		9	ne Park			1 8	8/23/00	Wood	lawn.	Mary!	Land
altimore, mil. Pages I al parament of Heapportant; if Hear; y Hijury or others.		21. Signature Eugenal Service Lo	onses	BOLLGE	22. Name a	nd Addr	ess of Facili	tv				7	
B FORTER	-	- Hours	Omnor	_	Lemmon						D 01	002	
		23a. Part1. Enter the disease, or co	mplications that course	ed the death. Do	1				, Timon:		D 21	093 Approxir	nate
311		shock, or heart failure. List on	ly one cause on each	line.	IOC BINES LING INC	30 OI Gy	ng, such as	Coldiac	or respiratory at	1031,		Intervel	Between nd Deeth
Physician			,								1	7	10
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	LUNG	CANCIU	20 KA - 1	467	AS MI	76) 10.	24057
- Examine		leading in death)	V	Due to (or as a	consequence of)	:							
D =	Examiner		b								1		
60, be executed ician and burial-transit	carr	Sequentially list conditions, if any, leading to immediate		Due to (or as a	consequence of)	:							
Geth certificate be executed the first of the first of the for use es the burtal-free of for use es the burtal-free of for use es the burtal-free of the formula for use of the formula for use es the formula for use of t	E	ceuse. Enter Underlying Cause (Disease or injury									170		
68760, ficate be expression of the buria	edicai	that initiated events resulting in death) Last	C.	Due to (or es e	consequence of)		1= -						
c 68	5												
BOX Beth ce attendii	Completed by Physician/		d								1		
D. El de de l'he att	sici	Part tt, Other aignificant conditions	contributing to death	but not resulting in	the underlying	ceuse g	iven in Part	l.	23b. Did 1	obacco usa	contribute	to the cau	as of death?
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cords, P.O.	y F												
rds Julies Jid b	B								24a. Was	an autopsy	24b.	Were autop	sy findings
Cord	et								peno	med?		completion of death?	
Has has	du												
The i									10	res 2∭N	0	1 □ Yes :	SIXI NO
of Vital In Physicien: The this certificate and director, page	Be	25. Was case referred to medical examiner?	Lines hel					e of Deat	h (Check only o	ne)			
Of Of Ohysic athis of the all directions of the ohysical directions of the	70	1 ☐ Yes 2 ☒ No	Hospitel: 15 Inpai			UA		ursing Ho	ome 5 Resid			city)	
	:uo	27. Manner of Death 1 ŽNatural 5 ☐ Pending	28a. Date of in (Month, D	ury 28b. 1	Time of njury	28c. Inju	ork?		28d. Describe I	now injury or	curred		
Attending r death.	ati	2 ☐ Accident investigat			M	1[Yes 2	No					
Division After de Directe d'in by t	tiff	3 Suicide 6 Could not 4 Homlcide determine	286. PIACE OF I	njury - At home, fa atc. (Specify)	rm, street, factor	y, office			28f. Location (: City or Tox	Street and Ni vn, State)	umber or A	ural Route N	lumber,
D late of in the control of in	Certification:												
I hours i unerel (hysician: To the bes										20(0)
Divi	edical	(Check only 2 Medical Ex	aminer: On the basis and manners		wor investigation	i, iii my	opinion, det	atti occuri	eo at the time,	uate and pla	oo, and out	O (FIE CEU!	10(3)
To the to	2	29b. Signature and title of certifier			29	-	se number			29d. Date si	gned (Moni	th, Dey, Yea	r)
V	1	/ Melent of	us Ms			UB	758			Augus	L Z1,	2000)
1/1/	14	30. Name and address of person with	o completed cause of	death (Item 23s)	(Type Print)					100	,		
10, 7	*	Richard Gros		4 Campbe		L	Thite	Mare	h. MD	21236			
		31. Date filed (Month, Day, Year)		trar's Signeture	/	0	4		,				
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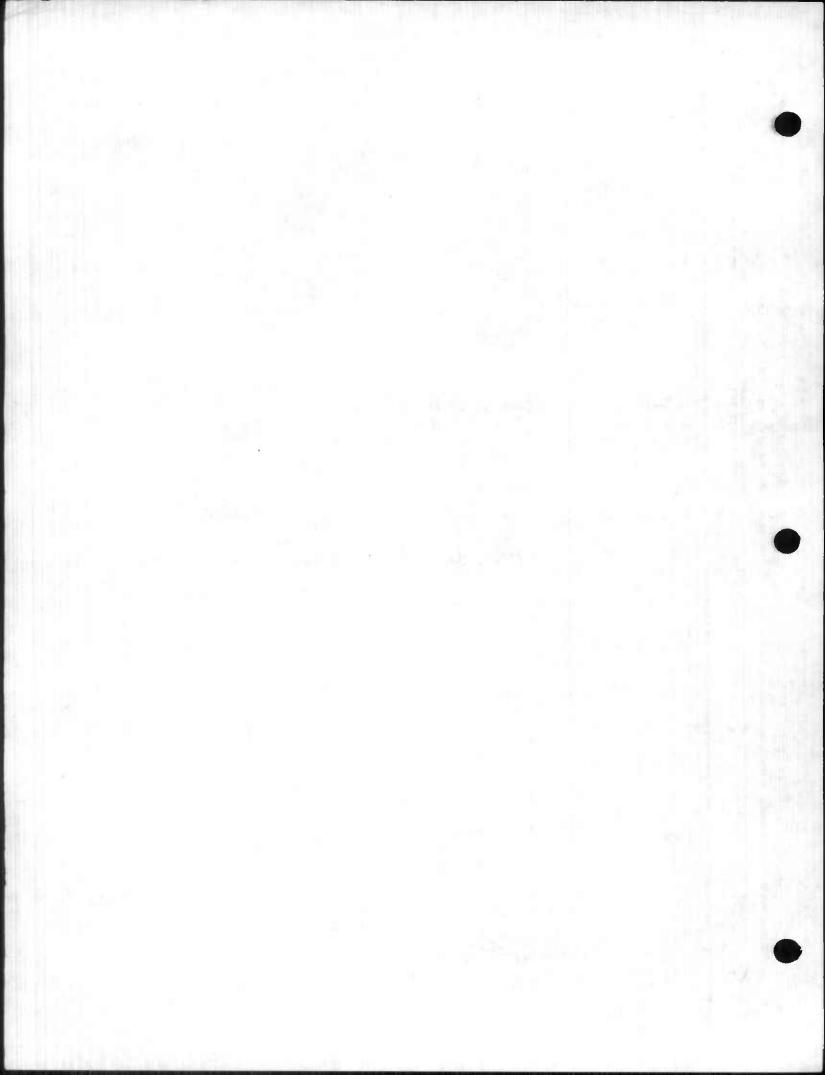
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State of Maryland / Department of Health and Mental Hygiene

			Certific	cate of		R	leg. No.	0 20	5512
Physician	Decedent's Name (First, Middle, La	est)				2. Date of Dee Month	Dey	Year	7.22 A
/Medical	4a Fecility Name (If not institution, gin	re street and number)	am		4b. City, Town, or L	Augus:	t 12		07:23 A.M
Examiner		General Hosp	oital		Baltin			N/A	
Funeral Director	5. Social Security Number 6.		yrs. lest birthday) If L	Inder 1 Year oths Days		8. Dete of Birth (Month, Day			a (Stete or Foreign
9 .	Usual Residence of Decedent	Lan	Oh T			1143		land	In ald and the bar
sthor sthor	10a. State 10b. County	100	City, Town or Location					100.	Inside City Limits 1 ☑ Yes 2 ☐ No
or 28s-f s be notified Director	10e. Street and Number	A		MOCE f. Zip Code			IOn Citizen of V	Vhat Country?	unknown
D PE	1411 Division	Shoot		71	217		og. Ottaor or v	mar occurry.	
thems 23a or 28a-f show siner must be notified at Funeral Director	11. Marital Status WAK nown	12. Wes Decedent Ever	in U,S. 13. Wes [Decedent of I	Hispanic Orlgin? (Span, Mexican, Puerto	pecify Yes or No-	14. Rac	a - American I	
ramine by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give	100	es 2 No	Specify:		Specify		
	15. Decedent's E	Yeer or Detes:	16a. Decedent's	Usual Occup	pation		16b. Kind of Bu	Known siness/Indust	lry
t, the Medical	(Specify only highest gri	college (1-4or 5+)	(Give kind of life. DO N	of work done OT use retire	during most of world)	king			
Com	unknown				un	known	unknow	0	
Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Meiden Sumen	re)	
To To		0	unknow				-		nown
Tage of	19a. Informant's Name/Relationship		411		t end Number or Ru	2			
9	Ansari Habib Abi	d'Al-Rahia	m 1411 Div		other c	Date	20c. Location -		
0	1 Burial 2 □ Cremation 3 E	Removal from State	cemetery, cremetory	y or other pla	(Ce)	lug. 18	2-11.		22.0
nu .	4 □ Donetion 5 □ Other (Special Signature of Funeral Service Lice		King Me	mon Addre	S of Facility VIL	Lbr Euro	eral Hor	nose T	no.
18	1				. 1 4 00				
	23a. Part1. Enter the diseese, or com shock, or heart failure. List only	onlications that caused the	death Do not enter the	9wyn	no such as cardiac	or respiratory an	tronone, 1	no . 21	216 proximate
physician end s the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events.	b	to (or as e consequenc	e ot):					
Man Man	that initiated events resulting in death) Lest	d	to (or as a consequence	e of):				1	
detached for use a	Part II. Other significant conditions	contributing to death but no	t resulting in the underly	ring cause gi	ven in Part I.	23b. Did t	obacco use co	ntribute to th	e cause of death?
by Phy						101	/88 2□No	3 Probeb	Unknown
eted			- 1			24a. Was perfor	an autopsy med?	availa	autopsy findings ble prior to letion of cause
page 2						101	es 200 No	1 🗆 Y	1
ŏ ø	25. Was case referred to medical				26. Place of Dea	th (Check only o			242
ToB	examiner? 1Å Yes 2□ No	Hospital:	2 XER/Outpatient 3	DOA Ot	hor:	ome 5 Resid		er (Specify)	
	27. Manuer of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Yea	28b. Time of Injury	28c. Inju	ny at ork?]Yes 2□No	28d. Describe h	now Injury occur	red	
ed in by the funari Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Pleca of Injury - building, etc. (S)	At home, farm, street, foecity)	actory, office	1	281. Location (S City or Tow	Street end Numb m, Stete)	per or Rurel R	oute Number,
completely filled	29e. Certifier 1 Certifying Pt (Check only one) 2 Medicat Exam	nysician: To the best of my miner: On the basis of exa and menner steted.	knowledge, death occumination end/or investig	urred at the teation, in my	ime, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) and madate and place,	anner as state and due to the	id. e cause(s)
To the	29b. Signature and title of pertifier	1 -1		29c. Licen	se number		29d. Date signe	d (Month, Day	y, Year)
7) VN	VI. Colo		0	.C.M.E.		Aug	ust 12	, 2000
20	30. Name and address of person who				-1 - 2 - 1 - 1			01000	
	JACK WI TITUS			n Stre	et, Balti	more, Ma	aryland	21201	
State	31. Date filed (Month, Day, Year)	2000 32. Registrar's S	Signature 4	Ann	No.				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18,2000 10 Se 9 /Medical 4e Facility Name (If npt institution, give street end number) 4b. City, Town, or Location of De c. County of Deat **Examiner** 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number . Age (In yrs. last birthday) 6. Sex Birthplaca (State or Foreign
 Opuntry) **Funeral** 14-64-2272 1□M 2♥F Director Usual Residenca of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at Maryland 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Meritel Stetus American Indian. Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life.; DO NOT use setired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 pernit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Itan 27 Ia marked other any Injury or other traumatic avant Father's Neme (First, Middle, Last) me (First, Middle, Maiden Surname) Be 19e. Informent's Neme/Relationship (Type, Print) (SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ry, crematory or other place) Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service/Licensee 22. Name and Address of Fecility 05 Ave. North WI 23a. Perf1 Entar the divesse, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final months disease or condition rasulting in deeth) Hepato allular Carcinoma Examiner Due to (or as a consequence of): Hepatitis C Vorus pass Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of deeth? 6 1 Yes 2 No 3 Probably 4 Unknown signed l by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 NO 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 StOther (Specify) 1 Yes 2 No Medical Certification: To of 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Division 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accidant Director 6 Could not be datamined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide A Hospital of 24 hours of Puneral Dietely filled in 29a, Certifier 16 Certifying Phyalcian: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number swelliam Y Semedict, mo 8/18/2000 D 000 8583

State Registrar

AUG 2 2 2000

G. William

31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

30. Name and eddrass of person who complated cause of death (Item 23a) (Type, Print) BENEDICT,

> sparke **ORIGINAL**

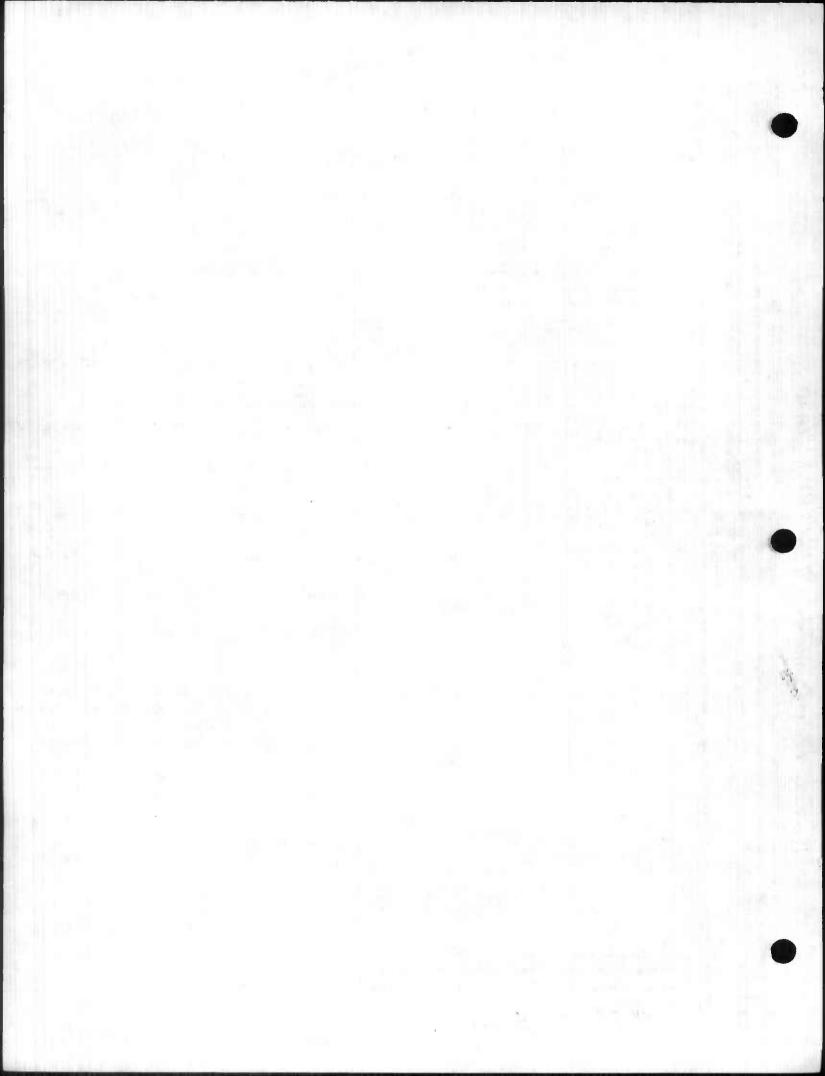
Baltimore

mo. 21204

6565 N. Charles

DHMH 16 Rav 6/95

O



				16.0	Cei	rtificate	e of l	Death			Reg. No.		20017
1. Decedent's Nem	e (First, Middl	e, Last)		15						2. Dete of De Month	eath Day	Year	3. Time of Death
JOHN	ANDRE	W SAN	DERS							August	19, 2	2000	3:55 AM
		n, give street and nu	m <i>ber</i>)		10		4			ocation of Dea		ounty of Dec	
Edenwald	Nursin	g Center						Tow	son		Ba	ltimo	re
5. Social Security N 212-28-16		6. Sex 1 → M 2 □ F	7. Age	(In yrs. last	birthdey) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D) Feb. 2	rth ey, <i>Year</i>) 2, 190	C	thplace (Stete or Foreign ountry) Md.
Usuel Residence of													
10e. Stete	10b. County			10c. City, To	own or Lo	cation							10d. Inside City Limits
Md.	Balt	imore		T	owso	n							1 Yes 21 No
10e. Street and Nur	mber					10f. Zip	Code				10g. Citizer	n of What C	ountry?
103 Kenil	worth	Park Dr.	Apt	. 2-B	B 21204			J	USA				
11. Merilel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S Armed Forces? 1 XYes 2 No It Yes, Sive Yeer or Dates: WW—II				If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 P No Specify:				14. Rece - American Indien, Bleck, White, etc. Specify: White					
(Spec		it's Education st grade completed)		16	Sa. Deced	dent's Usua kind of wor DO NOT us	l Occup	tion luring mos	of work	king	16b. Kind	of Business	/Industry
Elementery/Seco		College (1-4or 5+)										
17. Father's Name		4	-	עו	istr	ibuti	on M			ne (First, Middle			rewery
	(FI/St, MIDDIE,	Last/		0	,						e, Melden 30		
William					anders Wilhelmina 19b. Meiling Address (Street end Number or Rural Route Num				Kroening				
19e. Informent's No	me/Reletions	ship (Type, Print)		1	9b. Meilir	ng Address	(Street	and Numbi	or Rui	ral Route Numi	ber, City or T	own, State,	Zip Code)
20e. Method of Disp	osition Cremetion	nders/wif 3□Removelfrom ipecify)		20b. Plece ceme	of Dispo	enilwo esition (Nem metory or ot Rede	ne of ther plea	9)		. Apt. Dete 3/23/00	20c. Loca		n, Md. 2120 Town, State , Md.
21. Signature of Fe	maral Service	Liconage (D	-						al Home			
23e, Pert1. Enler II shock, or hee	ne disease, or rt feilure. List	complications that only one ceuse on	caused the	he deeth. D	o not ent	er the mode	e of dyin	g, such es	cardiec	or respiretory	arrest,		Approximete Intervel Between Onset end Death
Immediate Cause (disease or condition resulting in death)		. ME		TATI		SMAL	40	EU	CA	RCEN	MA	•	4 WK

Physician /Medical Examiner

Department of Health and Mental important: If them 27 is marked or any injury or other traumetic av page.

Physician

/Medical

Examiner

Funeral

Director

"natural", or flame 23s or 25s-f show

Funeral Director

py

Completed

To Be

Pages 1 and 2 should be tiled within 72 hours after death with the Maryla nent of Health and Mantal Hygiene. I Health and Mental Hygiene.

Then 27 is marked other than "natural", or flams 23s or 25s-4 show other treumetic swent, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

	Due to (or es e consequence of):
b	
	Due to (or es a consequence of):
c	
	Due to (or as e consequence of):

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 Yes 2 No Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth

1 Netural
2 Accident 28b. Time of Injury al Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for usa as the burial-transit Division of Vital Records, P.O. Box 68760,

29b. Signeture and little of certifier

29c. License number
D0014623

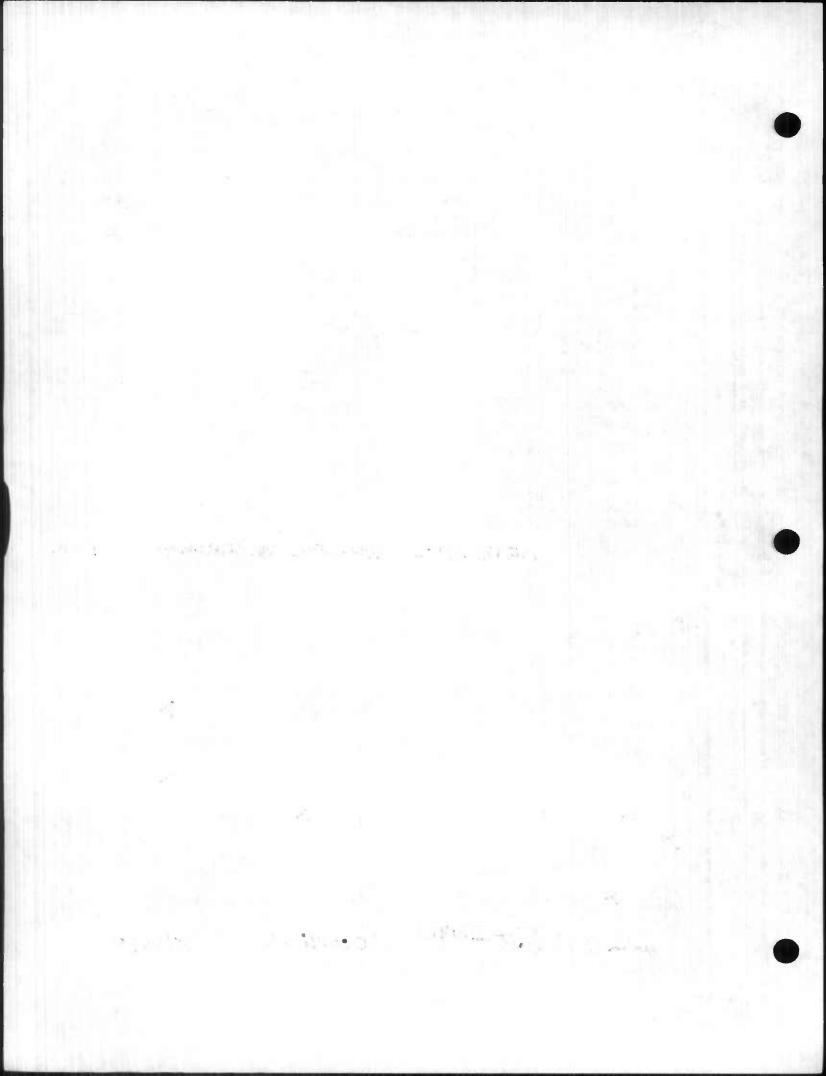
29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

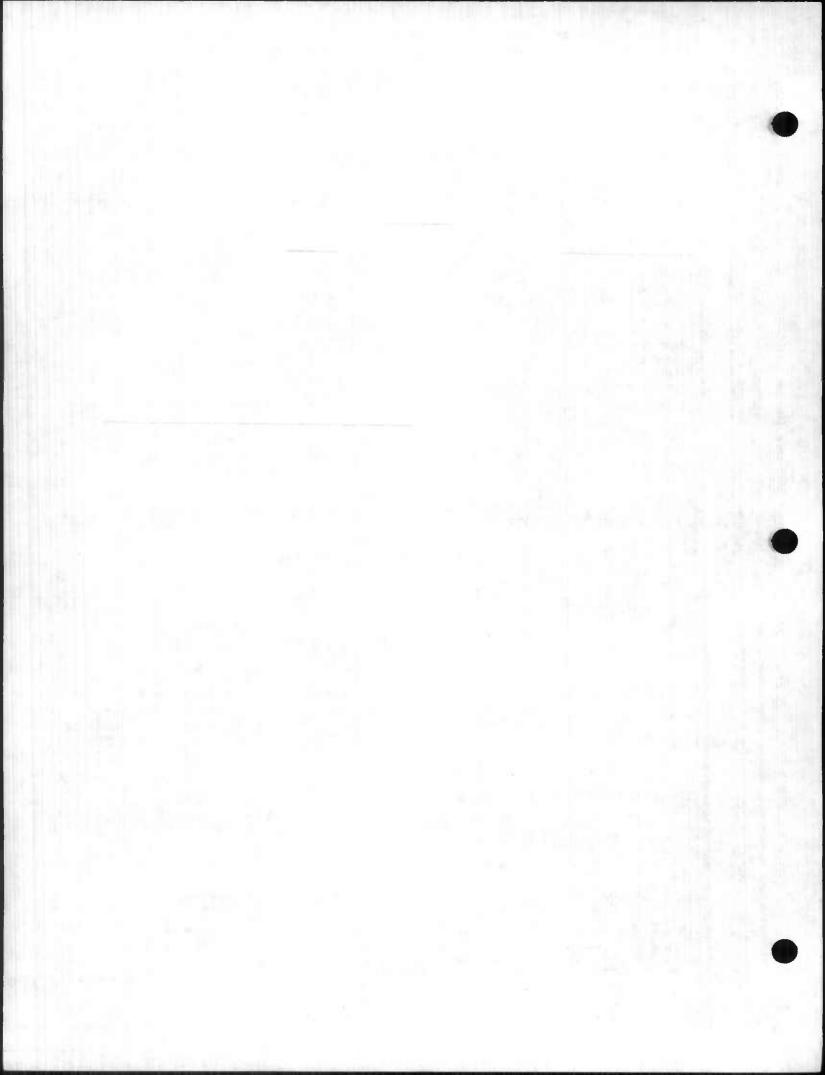
200 E. 33rd St. Baltimore, Md. 21218 John A. Nesbitt, M.D. 31. Dete filed (Month, Day, Year)

State Registrar

AUG 2 2 2000

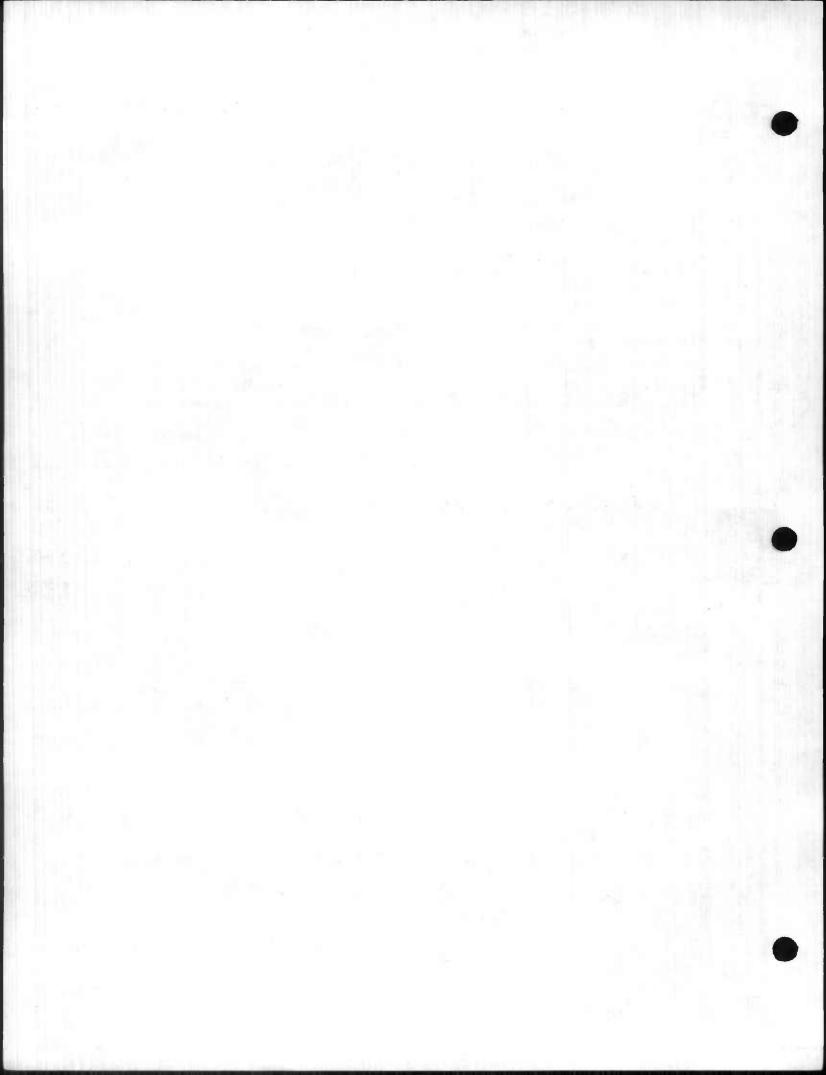


AUTIM M. SCLEGIBIATION FREDERICK FEWORTAL HOSPITAL FREDERICK MEMORTAL HOSPITAL FREDERICK FREDERICK FREDERICK COUNTY FREDERICK		1. Decedent's Name (First, Middle,			A DIESELV	Death	2. Date of De		3. Time of Death	
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Securitary Sec	mo	8		') Н	ousewife			Home	Owner	
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Comparing the contribution Comparing Service Usages			,	20b. Place of D	isposition (Name of					
21. Signature of Funeral Service Libraries 22. Name and Address of Facility MCCULTy-Polymiak Funeral Home P.A. 130 F. Fort Ave., Baltimore, Md. 21230 Approximate final condition and properties of the caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Immediate Cause (Final death) dease or condition resulting in death) Due to (or as a consequence of): Due to (or as a							1/2000	Baltimo	ore, Md.	
130 F. Port Ave., Raltimore, Md. 201230 Appendix of the cause of t				1)	22. Name and Addre	ess of Facility				
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24a. Was an autopsy finding available prior to completion of claus of death? 1	2		d						1	
24a. Was an autopsy finding available prior to completion of claus of death? 1		Part It. Other significant condition	s contributing to death bu	t not resuiting in th	ne underlying ceuse gi	iven in Part t.	23b. Dtd	tobacco use con	tribute to the cause of dec	
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25. Was case raferred to medical examiner? 1	by	Hypertension							available prior to completion of cause	
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27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 29a. Certifier (Check only one) 29a. Certifier 29b. Signature and title of certifier 29c. Licanse number 29c. Injury at Work? 28d. Describe how injury occurred 28d.	Completed by						perfo	Yes 20 No	available prior to completion of cause of death?	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Physician Stephanie Serdahely August 16, 2000 6:05 a.m. /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Howard If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Davs 10M 20F 96 Months Yrs. Director 212-74-4555 CZECHOSLOVAKIA AUG. 18, 1903 Usual Residence of Decedant 10h County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f HOWARD COLUMBIA must be notifi 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 5237 PAUL REVERE RIDE 21044 Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Meritai Status Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME Department of Health and Mertal Hygis Important: If then 27 is marked other any Injury or other transmissed other 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTAL ADAMOVIC (UNAVAILABLE) PETRAS 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5237 PAUL REVERE RIDE, COLUMBIA, MARYLAND 21044 of Disposition (Name of 20c. Location - City or Town, Stata LYDIA WALLACE/DAUGHTER 20e. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 1X Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) GARDENS OF FAITH CEM. 8/19/00 BALTIMORE, MARYLAND 21. Signature of Funarai Sarvice Licensae 22. Nema end Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Ceuse (Finai week disaesa or condition rasulting in death) Examiner Examiner 2 week eumon and Sequantially list conditions, it any, laeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? P.O. 94 signed by t 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed 2 12 No 1 ☐ Yes 2 ☐ No certificate 25. Was casa referred to medical axaminar? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? is of attending F setter death. I Director: After d in by the funer After Natural 5 Panding invastigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be 26f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Columbia MD 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State **AUG 2 2** Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ruth Virginia Strahler 2000 12:30 AM August /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months Days Hours 1□M 2♥F Yrs. 89 216-78-2553 Director NOV 10, 1910 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes Q No Director Maryland Baltimore Catonsville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code herna 23a ov 619 St. Johnsbury Road 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 8 Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumer id Mental marked or should be George A. Martin Sr. Abigail Garrnett and a 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) . Pages 1 and 2 s ment of Health an Department of Health Important: If Item 27 619 St. Johnsbury Rd. Catonsville, MD 21228
see of Disposition (Name of Date 20c. Location - City or Town, State Charles H. Strahler/Son Baltimore, 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a, Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 8 8-23-00 Lorraine Cemetery Woodlawn, MD any Injury once. 21. Signeture of Funeral Service Lie Translation of Lawrence A. Fewer Chik 22. Name and Address of Fecility
MacNabb Funeral Home 301 Frederick Road Catonsville, 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Physician/Medical Examiner eta Statio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequence of): The law requires that the death certificate be assect Box 68760. that initieted events resulting in death) Lest Due to (or as a consequence of): P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown bul cetton Division of Vital Records. þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Medical Certification: To Be Completed an 510 After this certificate hes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 1 Natural 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation s after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar **DHMH 16 Rev 6/95**

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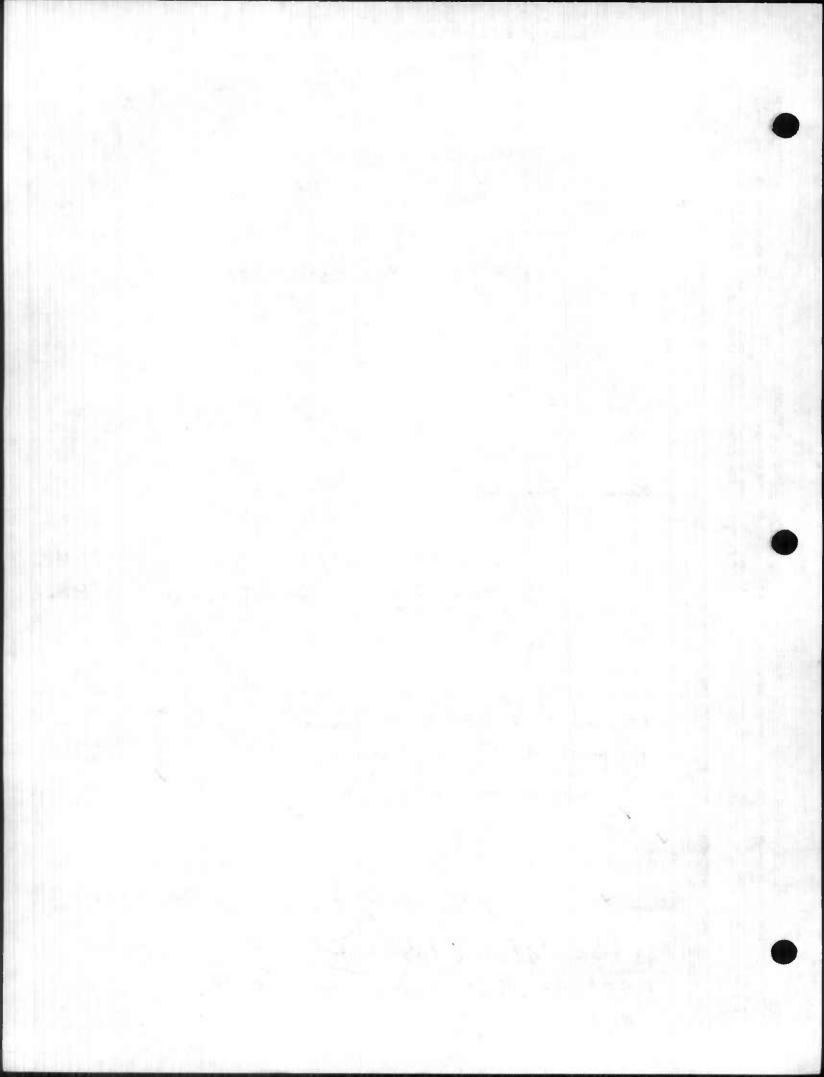
29b. Signature and title of certifier

38 18 32. Registrer's Signeture

30. Neme and eddress of person who, completed cause of deeth (Item 23e) (Type, Print)

290 License number

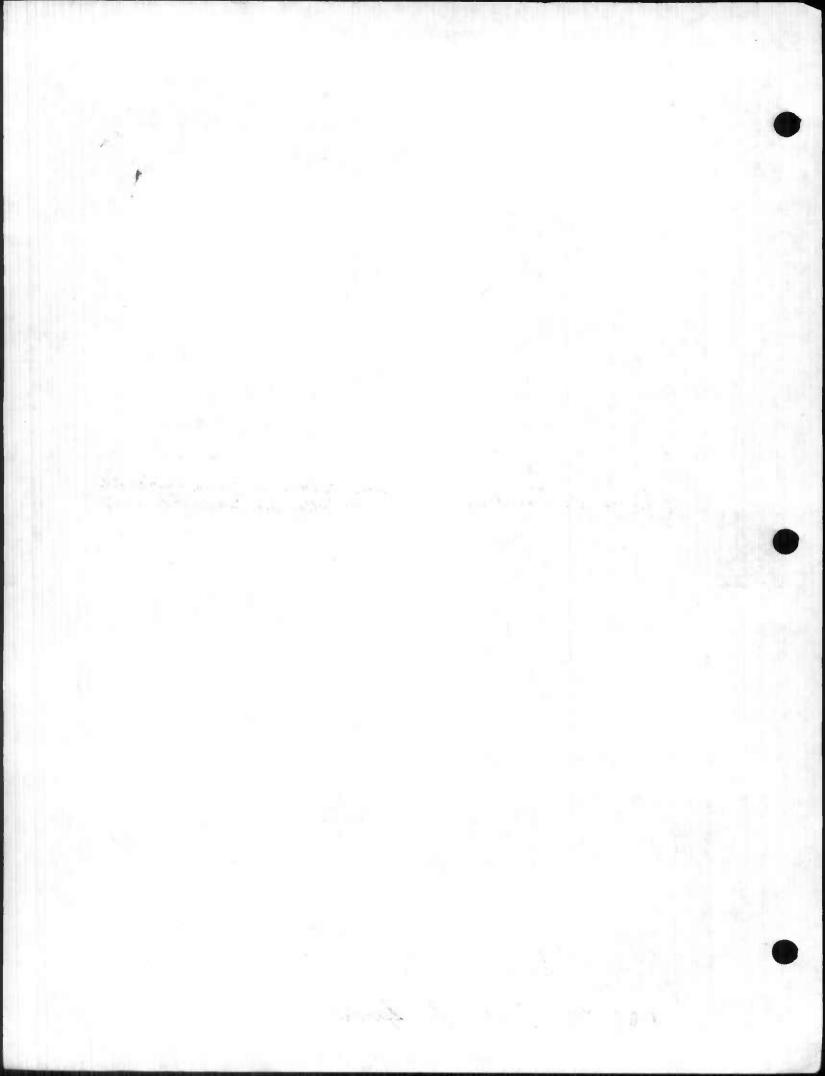
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State of Maryland / Department of Health and Mental Hygic

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	Amended	Item#23a,27,28a-f perMEOG788 10/12/2000 EW Certifica 1. Decedent's Nama (First, Middle, Last)	te of Death	2. Date of Dea	leg. No.	3. Time of Death				
	Physician			Month August		7ear 00 01:33 P.M				
	/Medical Examine	4a English Name /// And Institution when strend and numbers	4b. City, Town, or		4c. County of					
	LAGITITIC	208 South Bruce Street	Baltim	ore		N/A				
	Funeral Director	5. Social Security Number 2/5-98-28/5 125 M 2 F 7. Age (In yrs. last birthday) Month Usual Rasidence of Decedent	er 1 Year If Under 24 Hrs.		, Year)	D. Birthplace (Steta or Foraign Country) Md,				
	Maryland Handand	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☑ Yas 2 ☐ No				
21215-0020 d within 72 hours after death with the Manyland plene. If then "seturel", or fleme 23s or 28s-f show the beauties from the results of the confine of the confin	th with the Mar 23a or 28a-fa		(ip Code 21217	1	10g. Citizen of Wh	at Country?				
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5-0	ed within 72 ho yglene. her then "neturi rt, m. Medical	15. Decedant's Education (Specify only highest grade completed) (Give kind of w	ual Occupation	rkina	16b. Kind of Busi	ness/Industry				
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aryland	Hall H	17. Father's Nama (First, Middle, Last) Bobby JOE JUHNSON			Meiden Sumema)					
K	J Menderke		MAIN	ERINE	THOI	npson				
Ma	de d	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres 1536	ss (Street end Number or Ru			1d. 21217				
6	Head Per 2	20a Method of Disposition 20b. Place of Disposition (N	eme of		20c. Location - Ci					
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of Vital Records	The law requires that the death cert cate has been signed by the attending page 2 should be detached for use Completed by Physician/M			24a. Wes e perfor		24b. Were eutopsy findings available prior to completion of cause of death?				
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ta	vician: The certificate rector, pag	25. Wes case referred to medical	26. Place of De	eth (Check only or	ne)					
>	2 00		OOA Other: 4 Nursing H	lome 5 Resid	ence 6y Other	(Specify) Scene				
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۵	Tai Die			208 Bruce	e St,Balto,	Md				
	To the Mospital or Attending Physibin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral Medical Certification:		d at the time, date and plece on, in my opinion, death occu	e, end due to the durred at the time, d	cause(s) and menr dete and place, an	nar as stated. Id due to the cause(s)				
	To the Total	29b. Signature and life of certifier	9c. License number		29d. Data signed	(Month, Day, Year)				
		Theodor M. link mis	O.C.M.E.		Augu	st 15, 2000				
		30. Nema and address of person who completed suse of death (Item 23a) (Type, Print)								
		THE ONORE Milery 111 Penn S	Street, Balti	more, Ma	ryland 2	1201				
	State Registrar	31. Date filed (Month, Dey, Year) AUG 2 2 2000 G2. Registrar's Signature	h							

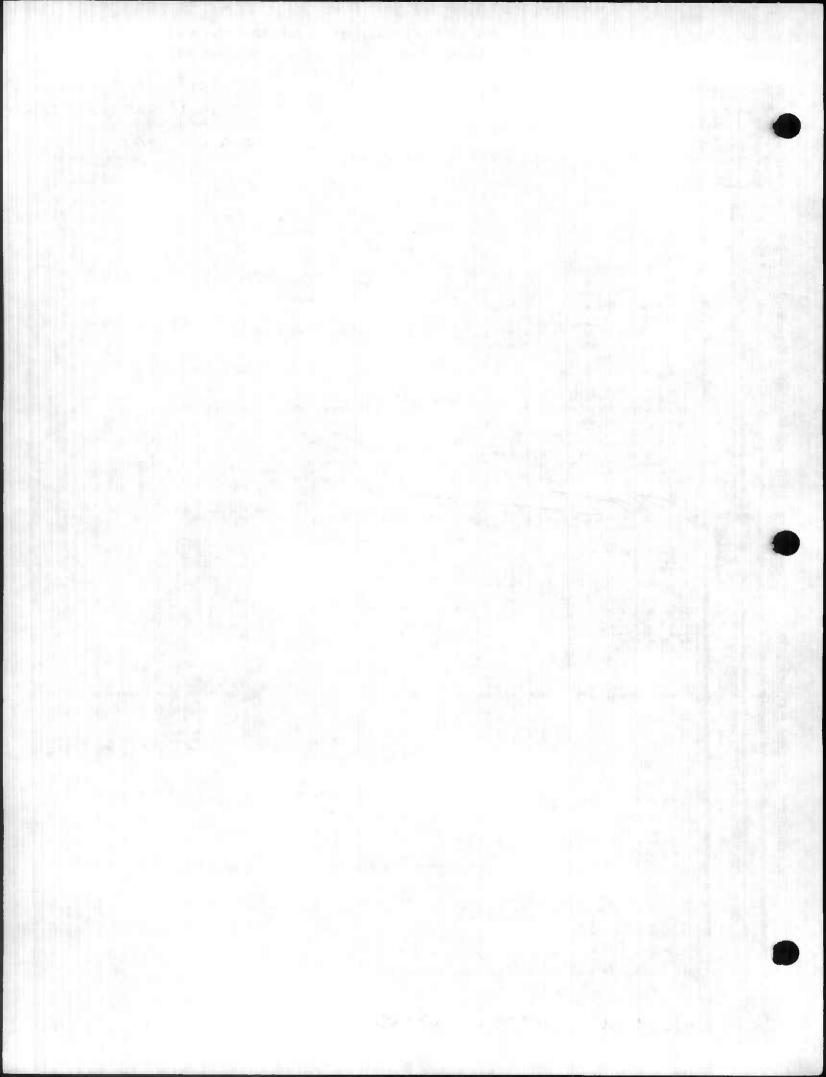


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State of Maryland / Department of Health and Mental Hygiene

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any le	21. Signatura di Punarai Sarvice	Licensee							HOME,	P.A.			
Important: if any injury or page.	1000						RAVEN			SON, MI	212	96	
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State of Maryland / Department of Health and Mental Hygiene

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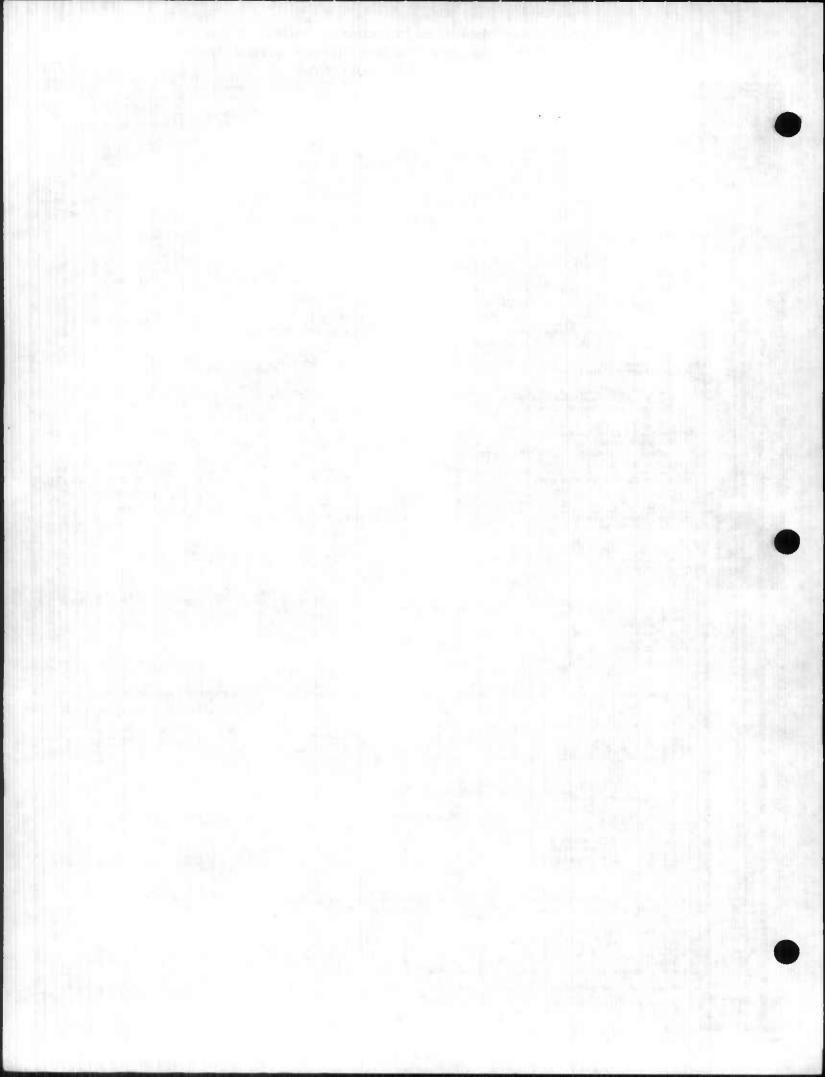
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	Funeral		5. Social Security Number 6. S		(In yrs. lest bi	Month		24 Hrs. 8. Dete of (Month)	Birth , Day, Year)	9. Birth	place (Stete or Foreign
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	with the Maryland a or 28a-f show	눕		14-1	- 100			,,	10g. Citizen o		0
	ler death with the Marylar frems 23s or 28e-f ehow her must be noutled at	Funeral		12. Was Decedent E		13 Was Day	2124	1	r No. 14 B	U.S.	4
	or Herr	5	11. Marital Status 1 Newer Married 2 Merried	Armed Forces?		If Yes, sp	edent of Hispanic Original Control Original Control of Hispanic Original Control Original Control Original Control Original Control Original Control Original Con	, Puerto Rican, etc.		Black, White,	, etc.
070	8 6 6	by F	3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes	2 No Specify:		Spe	city: BL	MCK
5-0020	natural,		15. Decedent's Ed		168	. Decedent's Us	ual Occupation		16b. Kind of	Business/In	ndustry
215		Completed	(Specify only highest gra	ade completed)		(Give kind of v life. DO NOT	rork done during most	of working			
212	iena. r then	EO	Elementary/Secondary (0-12)	College (1-4or 5+	,	SECI	RETAK	ex	U.S. C	GOVE	MOM EWZ
P	be filed withing that Hygiena. d other than event, the H	Bec	17. Father's Name (First, Middle, Last,				18. Mothe	r's Name (First, Mic			
ian		ToB	UAMES SHI	ACKELE	OKA		HA	-X55 1	UHUGI	1 (u	MKE)
Mary	s 1 and 2 should Health and Mer tem 27 le marke other treumatic		19a. Informant's Name/Relationship (19	b. Mailing Addre	ss (Street and Number	or or Rural Route No	umber City or Tov	vn, State, Zij	p Code)/
Σ	1 and 2 Health ar am 27 le		LEVEREND JOHN	L. Youw	9 1	11051	ANDOWA	1 6/RCZ	E, 15/12	HIM	roke, ma
ore,			20a. Method of Disposition	- /	20b. Piace	of Disposition (N	eme of other place)	Dete	20c. Locatio	n - City or To	own, State
Ε	Pagent: Mr. H		1 ■Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		HARM		MENOPIN	1 04 8-72-	OD LANY	DOVET	a min
Balti	Department mportant: any Injury		21. Signature of Funeral Service Licer	1988	00		and Address of Facilit				A Plant
m	Depa Impo any I	9	111,0lin 5	depus	ea)	4600	LIBER	HHE	14/50	AVE	NUE
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications thet caused	the death. Do	not enter the m	ode of dying, such as	cardiat or respirato	ry arrest.	07	Approximate
V	Physician		shock, or heart failure. List only	one cause on each line	Э.						Interval Between Onset and Deeth
	/Medical		Immediate Cause (Final	· Acute	Red	e land	Vasce	PW DO	Didgas	F	
	Examiner		disease or condition resulting in death)			consequence o		The ac	20000	1	
L		Jer				ulos	15/1/4	mia			
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions	b	, , 00	consequence o					
ó			Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Dinh	101	2					
68760	tificate be execu	edicai	Ceuse (Disease or injury thet initiated events	c. 101000	ue to (or as a	consequence of):				
_	5 9 8		resulting in death) Last								
Box	iras that the death cer signed by the attendir d be detached for use	Completed by Physician/M		d						1	
	deat de att	100	Part II. Other significant conditions of	contributing to death but	not resulting	in the underlying	cause given in Part I.	. 23b.	Did tobacco uss	contribute !	to the cause of death?
P.0	by th	J.	H ne-Densedo						1 Yes 2 N	0 3 Pro	obably 4 Unknown
	gned b	þ	MISERTURIO								
ord	v requires been sign should be	8	Seizenes.					24e. \	Was an eutopsy performed?	81	Vere autopsy findings vailable prior to
Records,	has be	ple	2000							of	ompletion of cause f deeth?
E	The I	E O	Decutorhis	VICER					Yes 2 No	1	Yes 2 No
Vital	ysicien: The lav s certificate has director, page 2	Be	25. Was case referred to medical				26. Place	of Death (Check o	nly one)		
1 <	Physicien: this certific	To	examiner?	Hospital:	t 2 ER/O	utpatient 3 1	OOA Other: 4 Nu	rsing Home 5	Residence 8 🗆	Other (Speci	ity)
n of	g Physical distribution		27. Manner of Death 1 DNatural 5 Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. Injury at Work?	28d. Desc	ribe how injury oc	curred	
0	Attending ir death. actor: After by the fune	atic	2 Accident investigation	n		М	1 Yes 2	No			
Division	recto	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injur building, etc.	ry - At home, f (Specify)	arm, street, fact	ory, office		on (Street and Nu r Town, State)	mber or Rur	ral Route Number,
0	tal of the load in Did										
	To the Hospital or Attending Physics and Physics of the Companies of	edical	(Check only 2 Medical Exer	ysician: To the best of niner: On the basis of e	examination at						
	Mr S	Med	one)	and manner state	ed.						
	5 68	-	29b. Signature and title of certifier			2	9c. License number	7. (29d. Date sig		
	101		THE PULL	Don &		Ł	000356	14	rugu	st d	-11 2000
	141		30. Name and address of person who	completed cause of de-	eth (Item 23a)	(Type, Print)	700 A -110	note to	Augu	2017	1715
-	011		Whales. ommon	o-cleinno	nspu	26001	iner THE	Justive	1 Day	1012	120
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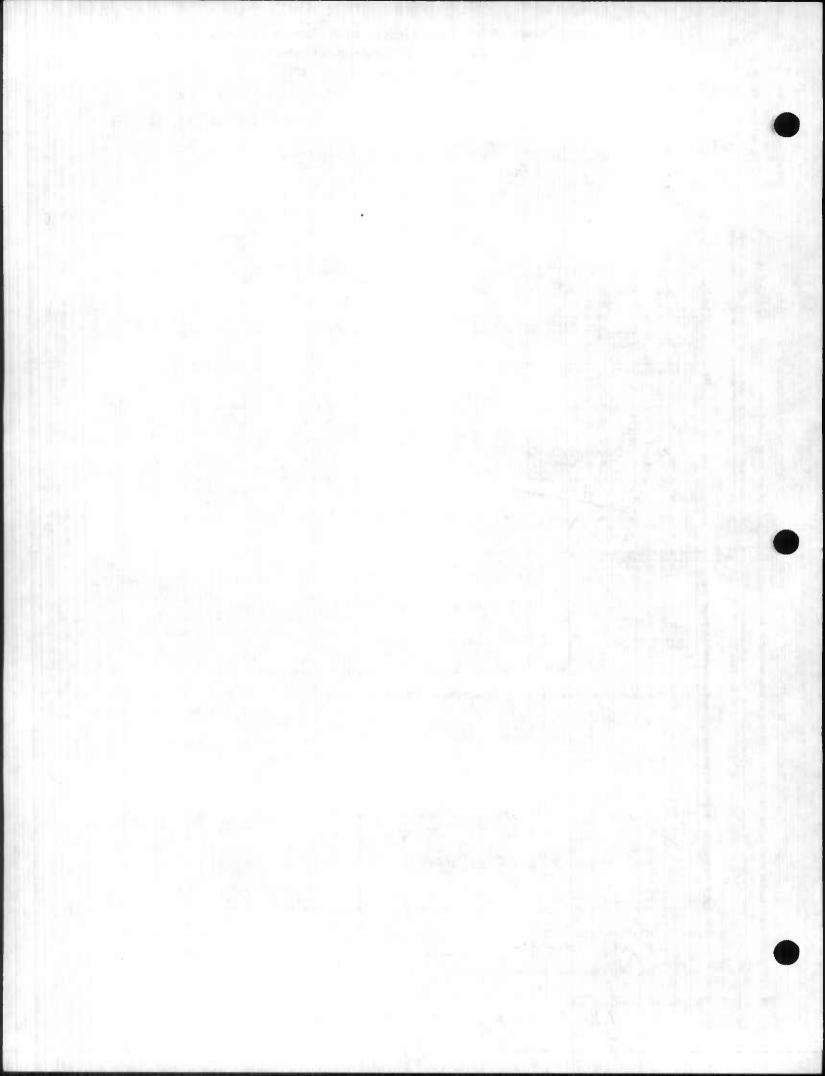


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		Otato or ini		Certifica:			and Mental H	Reg. No.	JU 6	26521
	1. Decedent's Name (First, Middle, Las	st)					2. Date of Month	Daath Day	Year	3. Time of Death
Physician /Medical	ANITA			W	ILSO		AUGUS	ST 18	2000	09:59
Examiner	4a Facility Name (If not institution, give THE JOHNS HOPK						wn, or Location of De		unty of Death	
Funeral Director	5. Social Security Number 6. Security Number 209-52-1818	9X 7. Ag	e (In yrs. last bin	thday) If Unde Months	Days	If Under : Hours	24 Hrs. 8. Date of (Month.) 06/05	Birth Day, Year) 5/1963	Cou	place (State or Forei intry) sylvania
2 .	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location						10d. Inside City Limi
or 28a-f show a notified at Director	VA Albemarl	e	Woodbr					0.00	1 □ Yes 2 N	
or 28e-f st be notified Director	10e. Street and Number		10f. Zip Code					10g. Citizen of What Country?		
2 24 1	1800 Sugar Hill D	rive #202		22192						
our after death aft, or items 23 Examiner must by Funeral	11. Merital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Race - Ameri Black, White ecity: WH	, etc.
"natur dical	15. Decedent's Ed (Specify only highest grad	ucetion de completed)	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)						of Business/Ir	
the Man	Elementery/Secondary (0-12)	College (1-4or !	5+) Te	Teacher						School `
s t and 2 should be find within 72 ho t Health and Mental Hygians. I see and Mental Hygians other treumstic event, the Medical To Be Completed	17. Father's Name (First, Middle, Last) James A. Wilson			18. Mother's Name (Fin Ella G. B.					meme)	
2 should and Mar is marks sumstic	19a. Informant's Name/Relationship (7	Type, Print)	19b	19b. Mailing Address (Street and Number or Rural Route Nu					own, State, Zi	ip Code)
and 2 lealth in 27 is	Molly A. Offutt	Sister		0 East	-	aker	Thurmont	MD 21	788	
or oth	20a. Method of Disposition 12 Burial 2 Cremation 3	Removal from State	cemeter	Disposition (Ne y, crematory or	other pla		Dete		ion - City or T	
mant mant jury	4 □ Donetion 5 □ Other (Specify		Rimer	sburg C			8/22	Rimersburg, PA		
Departing any in	21. Signature of Funeral Service Licen	S00			ng-A	shton	y -Schwab Fi venue Cato			
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that ceuse one cause on each li	the death. Do r	not enter the mo	de of dyir	ng, such as	cerdiac or respirator	y arrest,		Approximate Interval Between Onset and Death
/Medical	Immediate Cause (Finel disease or condition SEPSTS									FOUR DAYS
Examiner	resulting in death)	â	SEPSIS Due to (or as a	consequence of)):				1	OUR DAIS
nine at		b					- 246	1		
oa smecuted clan and curist-cransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.									
at the death certificate be d by the attending physicia etached for use as the bu Physician/Medical	that initiated events resulting in death) Last	d	Due to (or as a c	consequence of)						
the all the distribution of the distribution o	Part II. Other eignificant conditions of	. 23b. D	id tobacco ue	contribute	to the cause of deet					
ned by m e detacts y Phys	METASTATIC COL							□ Yee 2□1	No 3□Pre	obebly 40 Onkno
clerc. The law requires to entificate has been signe solor, page 2 should be d Be Completed by								as an autopsy erformed?	0	Vera eutopsy finding vailable prior to completion of ceuse of death?
The law site has page 2								Yes 2	lo 1	□Yes 2016
Sentifica ctor.	25. Wes cese referred to medical examiner?						of Deeth (Check on	ly one)		
To die	1 ☐ Yes 20 No	Hospital: Inpatie				4LINU	rsing Home 5 R			cify)
anth. x: After I he funer cation:	27. Menner of Death Netural 5 Pending Accident investigation		y Year) 28b. 1	rime of njury M	28c. Inju Wo 1 □	ry et rk? Yas 2 🗆		be how injury o	ccurred	
tal or Attending P rs after death. al Director: After I led in by the tursers Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, et	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					n (Street and N Town, Stete)	lumber or Ru	ral Route Number,
Houpi Na hou Funer Selvy fill	29a. Certifier (Check only one)	yeiclan: To the best liner: On the basis of and manner st	examinetion an	, deeth occurred d/or investigation	at the ti	me, date an opinion, dea	d place, and due to t th occurred at the tin	he cause(s) en ne, date and pla	d menner as ace, and due	stated. to the cause(s)
to the complete of the complet	30b. Signatura and title of certifier	20		29	c. Licens	se number		29d. Date s	igned (Month	o, Day, Year)
· ON	Julian	race	_		RE	S-000		AUGUS'	Г 18,	2000
O.N	30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Outle E. Park 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287									
State	31. Dete filed (Month, Day, Year)	32. Registr	ar's Signature	,						

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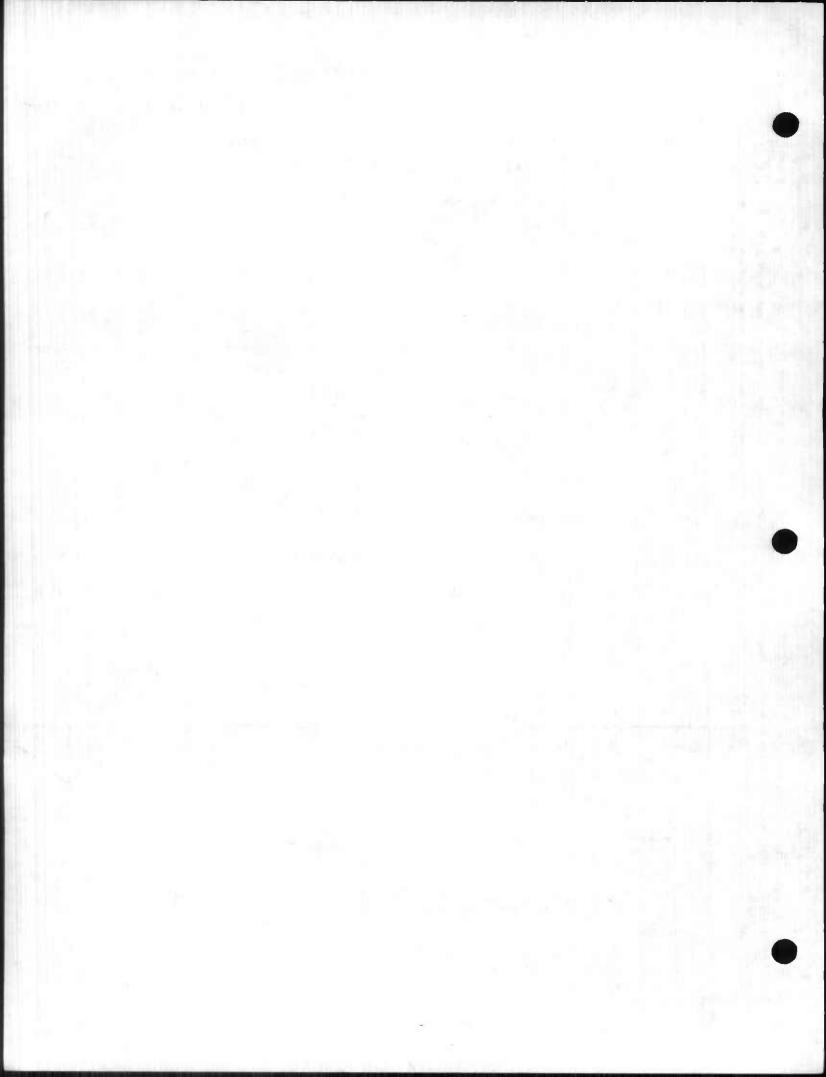
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2552

			Ce	rtificate	of Death	R	eg. No.	20026	
	1. Decedent's Name (First, Middle, Las	. 1		14.		2. Dete of Deet	h Dey Ye	3. Time of Death	
Physician /Medical	HNNE W	inters				August	15 200		
Examiner	4a Facility Name (If not institution, give HACOOK 165P)	1 4 1			4b. City, Town, or BAHW	nure	4c. County of D		
Funeral Director	215-22-3851	7. Age (In yr.	s. lest birthdey, Yrs.	Months D	ear If Under 24 Hrs eys Hours Min.	8. Dete of Birth (Month, Bey, NOV •	^v 1926 Ma	Birthplace (State or Foreign Country) aryland	
pue &	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits	
death with the Menyland me 23a or 28a-f show creat be notify at at neral Director	MD. Anne Ar		len Bur		Mark 1			1 ☐ Yes 2 No	
or 2	10e. Street and Number			10f. Zip Co		1	0g. Citizen of Whet	Country?	
23a rall	106 William Chambe				1060		U.S.A.		
020 urs efter hr., or fte	11. Meritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Detes:	U,S. 13.		of Hispenic Origin? (S Cuben, Mexican, Puer No Specify:	pecify Yes or No- to Rican, etc.)		umerican Indien, Thite, etc. Vhite	
5-0 72 ho	15. Decedent's Edi		16e. Dece	dent's Usuel O	ccupation one during most of wo	rking	16b. Kind of Busine	ess/Industry	
	(Specify only highest grad Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use re	etired)		Westingho	01150	
d 2. Hygier the mr. the results of t	17. Felher's Neme (First, Middle, Last)		Tele	phone O		me (First, Middle, A		Juse	
yianc ould be fi Mentei H arked oth artic ever						ine Kabbe			
Maryiand d 2 should be file th end Mentei Hy 7 is marked oth traumatic event To Be (Roy Boswell 19e. Informent's Name/Reletionship (7)	vne Print1	19b Mail	ing Address /S	reet and Number or R	urel Route Number	City or Town, Ste	te. Zip Code)	
and 2 saelth en n 27 is.	Charles Winters		106	William	Chabmers	Jr. Dr. C	len Burn	ie,MD. 21060	
Ore of Hear	20e. Method of Disposition 1 MB Burial 2 Cremetion 3 1 4 Donation 5 Other (Specify,	20c. Location - City Balto., M							
Baltim permit. Peg Deperment important: I any Injury o	21. Signature of Funerel Service License	A. Hilton	2	McCull	ddress of Fecility y-Polyniak			· 21122	
	23a. Pert1. Enter the diseese, or comp	lications thet caused the de	eth. Do not en		ountain Rd dying, such es cardia			Approximete	
Physician /Medical	shock, or heert feilure. List only o		liann	ic tin	eural e	Rusio/	\	Sweeks	
Examiner	disease or condition resulting in deeth)	a. Pue to	(or as e conse	quença of):	eum e	1100101	3	90056113	
P #				MICE				Syems	
OX 68760, certificate be assecuted ving physician end use as the burial-transit and AMedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	(or es e conse						
P.O. Box (et the death certified by the ettending eteched for use a Physician/M.	See II Others I will be a house distance	d	tales le ab	4-4:	a chara in Boat I	nah Dida		l l	
£ X 13 .	Pert II. Other eignificant conditions co		sulling in the	andenying caus	e given in Pert I.	/	23b. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Unknown		
COFC require						24a. Wes e perfori		4b. Were autopsy findings aveileble prior to completion of cause of death?	
The lew page 2						1 🗆 Y	es 2 No	1 Yas Tana	
r Vital Ho yelden: The l s: certificate ha director, page To Be Com	25. Wes case referred to medical				26. Piece of De	eth (Check only or	18)		
Of VITa Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 Reside	enca 8 DOther (Specify)	
After fune	27. Menner of Death 1 Meturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time Injury	of 28c.	Injury el Work? 1 Yes 2 No	28d. Describe he	ow injury occurred		
DIVISION (but or Attending P rs after deeth. at Director: After t led in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pleca of Injury - At building, etc. (Spec	home, ferm, e	treet, fectory, o	fica	28f. Location (S. City or Town	treet end Number on, Stete)	or Rurel Roule Number,	
DIVISION O To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam			er es stated. due to the ceuse(s)					
withir To the comp	29b. Signely and title of certifier	1000			cense number		29d. Dete signed (A		
5	1 Jeter C	cin mis		105001				15,2000	
CO'	30. Name and address of person who of Peter Crais MD, 3	ompleted cause of deeth (Its	em 23a) (Type	Street	Baltimo	re, Mnry	Imd 21	225	
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Sig	nature	8	books				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year

19

August

4b. City, Town, or Location of Death

2000

Anne Arundel

4c. County of Death

3:07a.m.

Birthplace (State or Foreign Country)

Physici /Medio Examir	al	1. Decedent's Name (# Doris Wic 4a Facility Name (# no Hospice H	iell et Institution			ımber)		
Funeral Director		5. Social Security Number 6. Sex 7. A 1						
ter death with the Maryland flows 23e or 28e-f show ther man be not led at	stor		cedent Ob. County Winne	ba	go			
th with the 23a or 28a	uneral Director	10e. Street and Number 2750 N. Mulford						
Nome 2	uner	11. Meritai Stelus	2□ Marri	od	12. Wes Dec	orces?		

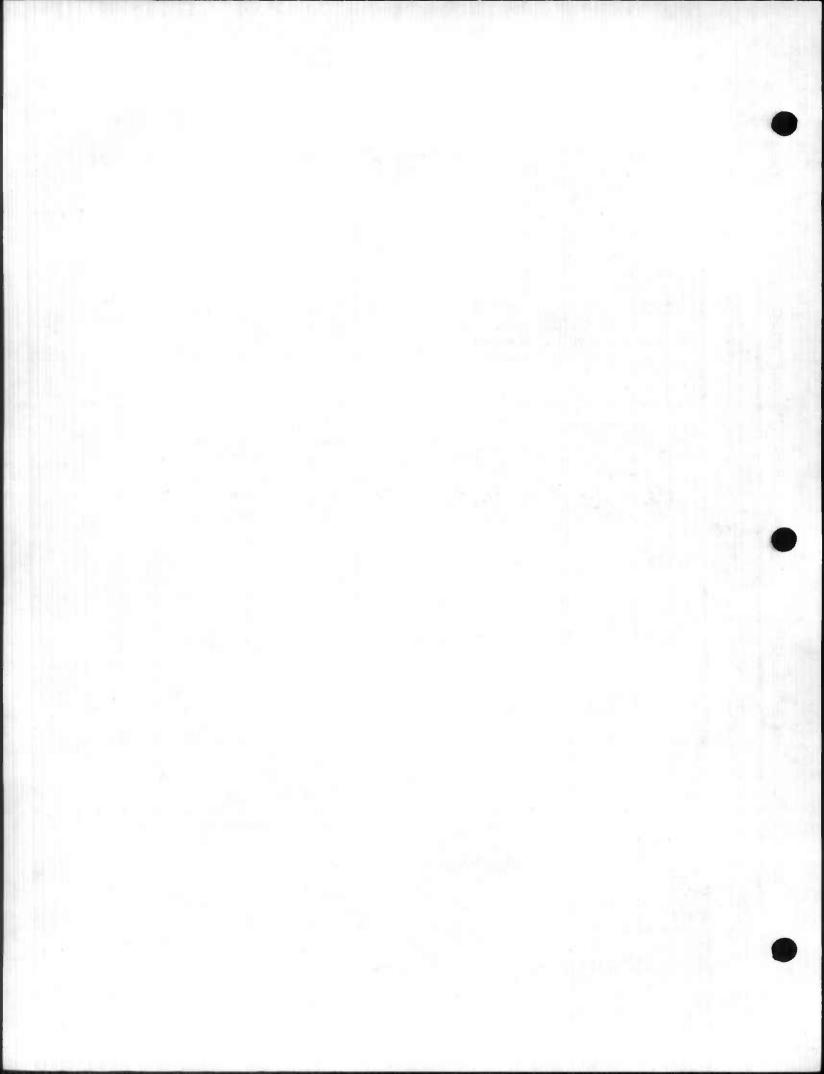
Hospice House Linthicum | Munder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 8 1924 . Social Security Number 7. Age (In yrs. last birthday) 1□ M 2♥ F 338-16-5807 76 Usual Residence of Decedent Oa. Stete 10b. County 10c. City, Town or Location IL Winnebago Rockford Oe. Street and Number 10f. Zip Code 2750 N. Mulford 61108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Maritai Stalus 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or eny injury or other traumatic event, the Health English page. 1□ Yes 2√No Specify: Baltimore, Maryland 21215-002(P 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Fethar's Neme (First, Middle, Last) Be Albert Johnson Ellen Weisman 19a. Informent's Name/Reletionship (Type, Print) Nancy Landers - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) □ Donetion 5 □ Other (Specify) 21. Signature of Fungraj Service Licensee **Physician** /Medical Immediete Causa (Final LUNG diseese or condition resulting in deeth) **Examiner** Examiner physician and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Last Due to (or es a consequence of): Box 68760, Physician/Medical Dua to (or es e consequence of): 980 P.O. ata has been signed by the a page 2 should be detached Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, p Be Completed certificata has Division of Vital 25. Was case referred to medical axaminer? director, 26. Place of Death (Check only one) 1 Yes 2D No 27. Manner of Death Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? After 1 Neturel 2 Accident 5 Pending 1 Yes 2 No 24 hours after death. investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Medical completely (Check only one) To the F within 2 To the F 29c. License number 29b. Signature and titla of certifian 041339

Illinois 10d. Inside City Limits 1 Yes X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Bleck, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 West Drive Severna Park, MD 21146 20c. Location - City or Town, State Sunset Memorial Gardens 8/22/00 Rockford, Illinois 22. Name end Address of Facility Witzke Funeral Home 1630 Edmondson Avenue Catonsville, MD 21228 or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Ho SPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 08-20- 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 LOVE Pr RD JAME HARMS MO STEVENSVILLE MO 21666 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Deper AUG 2 2 2000

State

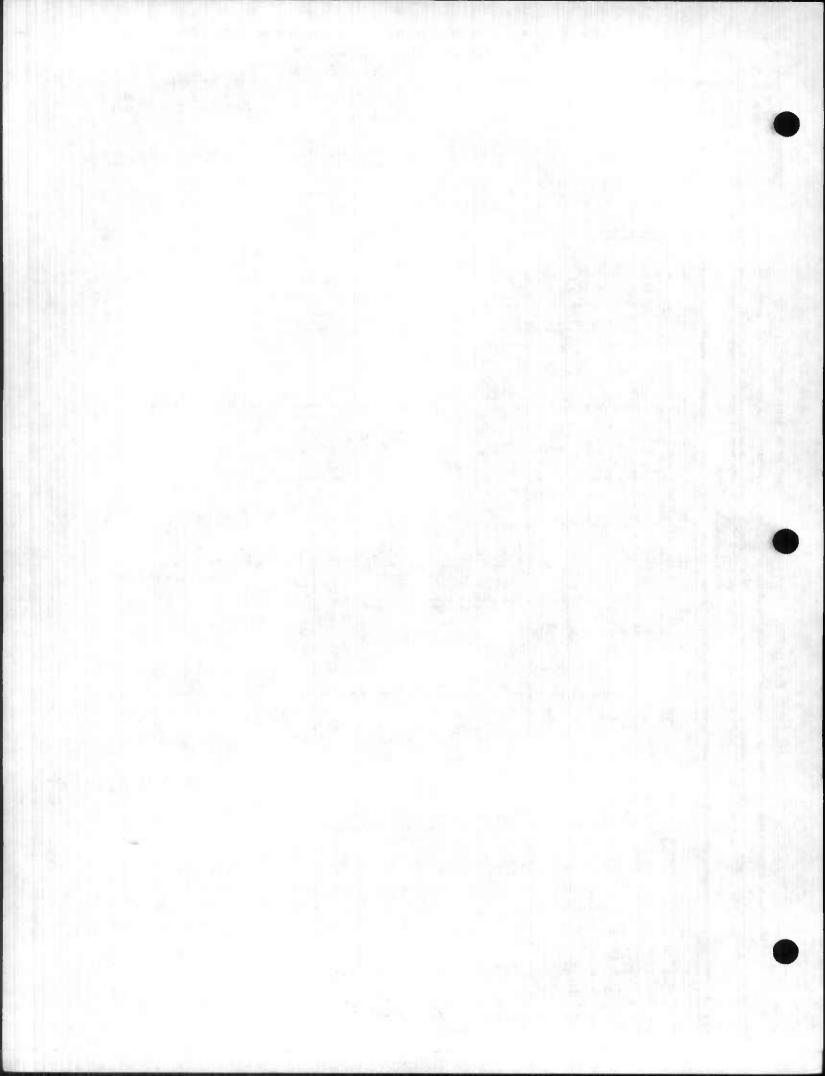
Registrar



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	Certificate of Death	Reg. No.	00 26524
Physician		2. Date of Death Month Day	3. Time of Death
/Medical		fugust 20	
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loca Injon Memorial Hospital Baltimore		County of Death N/A
	onion remotiat hospitat		
Funeral Director	Months Days Hours Min.	3. Data of Birth (Month, Day, Year) July 13, 19	9. Birthplace (Stele or Foraign Country) 114 North Carolina
ahow	10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits
with the Maryland to or 28a-f show the notified	Maryland N/A Baltimore City		1 No Yas 2 No
vith the Ma	10e. Street and Number 10/12 101. Zip Code	10g. Citize	en of What Country?
th with	830 W. 40th Street 21211	I	JSA
de File	11. Marital Status 12. Was Decedant Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Vas., specify Cuban, Mexican, Puarto Ri	ify Yes or No-	Race - American Indian, Black, White, atc.
by by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas:		Specify: White
ed within 72 hours ygiene. or then "netural", it, the tredical Es	15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind	d of Businass/Industry
within then.	Elemantary/Secondary (0-12) Collega (1-4or 5+)		
Hygier the transfer transfer the transfer transfer the transfer transf	4 yr Homemaker		vn Residence
ould be filed v Mental Hygie arked other t antic avant, th	17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden S	итета)
d 2 should be filed th and Mental Hyg 7 is marked othe traumatic avant,	Ernest Merlin Schenck 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural)	olumbia Kel Routa Number, City or	Town, Stete, Zip Code)
P PE PA L	Mrs. Kelly Watkins Painter 5610 Enderly Road, Balt		
	20a. Mathod of Disposition 1 A Burial 2 Cramation 3 Removal from State 20b. Place of Disposition (Nama of cematery, cramatory or other place)	Data 20c. Loc	ation - City or Town, State
Pag nent mrt; h		24/2000 Ran	mseur, North Caro
pemit. Page Department of Important: If any Injury or once.	21. Signature of Funeral Sarvior Licentum 22. Name and Addrass of Facility		
89729	Martin D. Lawson Mitchell-Wiedefeld	Funeral Hon	ne, Inc. cyland 21212
	Martin D. Lawson Martin D. Lawson 6500 York Road, Ba1 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or shock, or haart failure. List only one cause on each line.	raspiratory arrast,	Approximate Interval Batween
Physician			
/Medical	Immediata Causa (Final disaasa or condition Lung (a, Squamous Cell, 1	RILL, ig Vas	ianto 3 weeks
Examiner	Immediata Causa (Final disaasa or condition resulting in death) a. Lung Ca, Squamons Cell, I Due to (or es a consequence of):	Calattriw t	76 (900
P z c			
ate be asscuted thysician and the bunal-transit dical Examiner	Sequentially list conditions, Dua to (or as a consequence of):		
icata be an physician as the burial	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury		
	that initiated evants resulting In death) Last Dua to (or as a consequence of):		
	d.	X JUNEAU LO	
The law requires that the death certificate has been signed by the attending page 2 should be detached for use a:			
the de sy the ached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco u	ise contribute to the cause of death
ed by detac	post obstructive phenmonia	1 X Yes 2	No 3 Probably 4 Unknow
he law requires that the de a has been signed by the isge 2 should be detached ompleted by Physic	Acute Renal failure	24a. Was an autops	24b. Wara autopsy findings
v requires been sign should be	Acate Klunk Failure	performed?	available prior to complation of cause
has the 2 s			of death?
ysician: The lay is certificate has director, page 2		1 ☐ Yes 2∕	No 1 Yas 20 He
Physician: This certificate in director, pure of the Co. To Be Co.	25. Was casa rafarred to medical examinar? Hospital: Other: Other:		
this of the To	1 2 EN/Outpatient 3 DOA 4 Nursing Hom	a 5 Rasidance 8 8d. Dascribe how injury	
Ing I	12 Natural 5 Pending (Month, Dey Year) Injury Work?	od. Dascribe now injury	Cocorred
tal or Attending P is after death. al Director: After t led in by the funare Certification:	2 Accident	Rf Location (Street and	Number or Rural Routs Number,
or Attending after death. Director: After J in by the funa ertification	4 Homicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)	City or Town, Stata)	Transfer of Transfer Today Transport
	29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, an	nd dua to the causa(s) a	and manner as stated.
he Hospi in 24 hou he Funer pletely fill edical	(Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred and manner stated.		
ro the vithin round on the comp	29b. Signature and title of certifier 29c. License number	29d. Date	signad (Month, Day, Year)
.~	1 Yay 52h, m.D D 53654	Augu	15+,20, 2000
10	30. Name and appress of person who completed causa of death (Item 23a) (Type, Print) YAO -YAO ZHU Union Memorial Hospital 31. Data filed (Month, Day, Year) 32. Registrar's Signature ALIC 9 2 2000		
State	31. Data filed (Month, Day, Year) 32. Registrar's Signature Aparts		
Registrar	AUG 2 2 2000 Pent		
HMH 16 Rev 6/95			

ORIGINAL

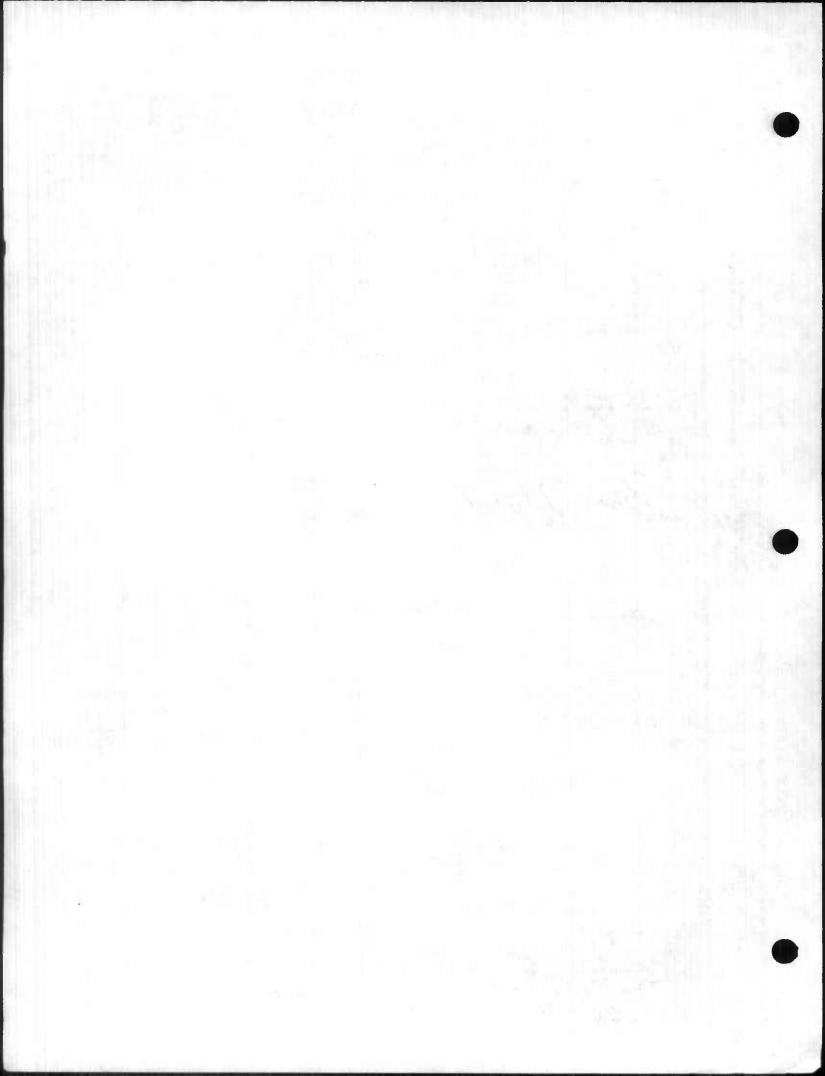


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State of Maryland / Department of Health and Mental Hygiene

BETTY WAT		Decedent's Name (First, Middle, L.)	#23 PAI		00	unca	10 01	Doam	2. Date of Do		Year	3. Tima of Death
Physicia /Medic		Betty					Wat	son	AUG.	16, 200	0	1544 PM
Examin		4e Facility Name (If not Institution, gl 3116 PRESSMAN)				4b. City, Town, o	r Location of Deal			
Funeral Director		215-70-7218	Sex 7. A 1 □ M 201	ge (In yrs. 41	last birthday) Yrs.	If Undo	er 1 Year Days	If Under 24 H	n. (Month, D	oy, Year)		lace (State or Foreign try) • D •
2 *	-	Usual Residence of Decedent 10e. Stete 10b. County		10c City	y. Town or Lo	ocation					1	Od. Inside City Limits
20 atter death with the Maryla or Herns 23s or 28s-f shor priner, must be notified at	Director	MD NA			timor	e						1 XYes 2 □ No
10 00 00	눔	10e. Street and Number				10f. Z	ip Code			10g. Citizen of W	/hat Cour	ntry?
123a	=	3116 Pressman					2121		Ų.S.A.			
y de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Dec If Yes, sp	edent of hecify Cub	lispanic Origin? an, Mexicen, Pu	(Specify Yes or Natro Ricen, etc.)	D- 14. Hace Blac	e - Americ k, White,	an Indian, etc.
UZU Nrs atha Nr. or il Examin	by	XXNever Merried 2 Married 3 Widowed 4 Divorced	1 Tes 2 2 If Yes, Give Year or Dates:			1 🗆 Yes	2 X) No	Specify:		Specify: Black		
Marytand 21215-0020 d 2 should be filed within 72 hours at his and Market i Hygiers and natural; or 7 is marked other than "natural; or traumatic event, the Medical Exam	Completed	15. Decedent's E (Specify only highest gi	ducetion ade completed)		16a. Dece (Give	dent's Us	val Occup	pation during most of w	orking	16b. Kind of Bu	siness/Ind	dustry
Man Ban Ban Ban Ban Ban Ban Ban Ban Ban B	Ē	Elementary/Secondery (0-12)	College (1-4or	5+)		perv				Tasty	Nut	
Digital I		12th grade 17. Father's Name (First, Middle, Las	na D		Sup	JEL V	1501	,	ame (First, Middle	, Maiden Sumam		
ed be ed be	m	Moses Watson							- Cash			
2 should and Men is marks	2	19a. Informant's Neme/Relationship	(Type Print)		19b Maili	na Addre	ss (Street		a Scot	per, City or Town,	State, Zic	Code)
and 2 salth ar 27 ts										altimor		
Health Health Mars 27 Other tr	+	Melvina Watsor 20a. Method of Disposition	I-MOCHEL	20b. P	lace of Dispo				Date	20c. Location -		
emit. Pages 1 a Separament of Hea mpoctant: if Item iny Injury or othe		1 XBuriel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ng Me	emor	ial	Park		Randa	llst	own, Md
Depart Depart mpoorn any in		21. Signature of Funeral Service Lic	Mrs	1	2	Marc Marc	h F	7H West	e, Bal	timore	Md	21215
		234 Part1. Enter the disease, or cor	nplications that couse	d the death								Approximate Intervai Between
Physician		shock, or heart failure. List only	one ceuse on eech	iine.							1	Onset and Death
/Medical	9	Immediate Cause (Finat		NARC	OTIC	INT	OXIC	ATTON			1	
Examiner	-	Immediate Cause (Finat disease or condition resulting in death) NARCOTIC INTOXICATION a. Due to (or as a consequence of):										
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and all-trans	Examiner	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury	b	Due to (o	r as a conse	quence of	f):					- 10/12
death certificate be executed the attending physician and ad for use as the burial-transit.	edicai	Cause, Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):										
attending for use	Physician/M	R. P. San L.	d									
) a = £	ysk	Part II. Other algnificant conditions	contributing to death	but not resi	ulting In the u	ınderlying	ceuse gi	ven in Part I.				o the causa of death?
	by Ph								_ 10	Y88 2 (No	3∐ Pro	bably 4 Unknown
Physician: The law requires the certificate has been signeral director, page 2 should be considered.	Completed b									s en eutopsy formed?	av	ere eutopsy findings railable prior to impletion of cause death?
The la ate ha page	E								192	Yes 2 No	1	Yes 2□ No
ician: The		25. Was cese referred to medicel						26 Place of [eath (Check only	onel		
Physician: this certific ral director,	o Be	examiner? 1∑ Yes 2□ No	Hospitel:	ient 2	ER/Outpatie	nt 3 🗆 [OCA OL	her.		sidence 6 XOth	ar (Speci	AT SCENE
	-	27. Menner of Deeth	28e. Dete of In	iurv	28b. Time o		28c. Inju		1	how injury occur		" AI SCENE
ding it.	100	1 ☐ Naturat 5 ☐ Pending 2 ☐ Accident investigeti	8-16	- 0 0°	504n	d :м		Yes 2 No	SUBJE	CT INGE	STE	D DRUGS
I or Attending after death. Director: After	Certification:	3 Suicide 6X Could not determine	28e. Ptece of tribuilding, e	etc. (Specif	me form at	reet, facto	ory, office HOM	E.	28f. Location		er or Rur	al Boute Number. RESSMAN S
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	edicai C		hysician: To the bes miner: On the basis end manners	t of my kno	wledge, deat	h occurre	d et the ti	me, date and ple	ce, end due to the	cause(s) and me	ennar es s	
ithin b the	Ž.									29d. Date signe	d (Month,	Day, Year)
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		20 Nome and a time of	· · ·	door to	00e) (T	Deinst	0	.C.M.E		AUG.	1/,	2000
		30. Name and address of person who	completed ceuse of									
01		JACK MIT 31. Date filed (Month, Day, Year)	32 Ranie	trar's Şigna	III Pe	nn S	tree	t, Balti	more, Ma	ryland 2	1201	
Sta Registr		AUG 2 2 2000	Seneral	4	10-							



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B.K.S	ANY	State of M		•			and Mental H	lygiene	0 2	6526		
JOSHUA AMA	AMENDED ITEM# 20d I		0101 SS	Certificat	e of L	Death	2. Date of	Reg. No.		Time of Death		
Physician	Joshua	Ryan	Ama	an			Month AUG.	6, 2000		9:37 PM		
/Medical Examiner	4e Facility Name (If not institution,	The state of the s)		4		wn, or Location of De	,				
<u> </u>	MEMORIAL HOSP 5. Social Security Number		ge (In yrs. lest bin	thday) If Under	1 Yeer	CUMB If Under:	ERLAND	ALLE		(State or Foreign		
Funeral Director	235-31-3360	X M 2□ F	10	Yrs. Months	Deys	Hours	Min. Septenth	Birth Year 981	Country)		
pu *	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Lim				
Maryli First and		eral		Ridgele	У					1 XYes 2 □ No		
with the Ma 3a or 284-1 s at be norther	10e. Street and Number P.O. Box 348			10f. Zip	Code	267	53	10g. Citizen of V USA	Vhat Country?			
d 21215-0020 filled within 72 hours after death with the Maryland Hygiene. ther than 'natural', or items 23s or 28s-1 show not, the Madical Ensirters must be notified as Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Force d 1 Yes 2 H Yes, Give Year or Dates:	?	13. Was Decedif Yes, spec		ispenic Origin, Mexicen Specify:	gin? (Specify Yes or , Puerto Rican, etc.)		e - American Ir ck, White, etc.			
ges 1 and 2 should be filled within 72 hours aft to 4 fleelih end Mental Hygiene. It of Heelih end Mental Hygiene. It of Heelih end Mental Hygiene. or other traumatic svent, its Hadical Ensure or other traumatic svent, its Hadical Ensure To Be Completed by F	15. Decedent's (Specify only highest Glegientary/Secondary (0-12)	Education grade completed) College (1-4or	5.1	Decedent's Usua (Give kind of wor life. DO NOT us DOYCE	rk done o	during most	of working	Food L				
Maryland 212: d 2 should be filed within th end Mental Hygiene. T is marked other than traumatic svent, the M TO Be Comp	17. Father's Name (First, Middle, L.	ast)					rs Name (First, Mid rah A (de, Maiden Suman Parker)	ne)			
and 2 should selfth end Men n 27 is merken traumatic.	Deborah Aman	ip (Type, Print)	P 195	Mailing Address BOX	348	; Rid	geley WV	nber City or Town, 26753	State, Zip Coo	ie)		
Pages 1 and 2: hent of Heelth ei nit: if hem 27 is	20a. Method of Disposition		cameter	Disposition (Narry, crematory or o	ther plac		Date	20c. Location -				
Baltimore, permit. Pages 1 e Important: If her any Injury or other other others.	4 Donation 5 Other (Sp. 21. Signature of Funeral Service L.		şunset		eAlde:	of Faul	k 8/11/ meral Ho MD 21502			MD		
Physician /Medical Examiner Examiner	23a. Part1. Enter the disease, or of shock, or heart feilure. List of limmediate Cause (Final disease or condition resulting in death)	a. Corrections that cause on each	Oue to (or as a	Consequence of):	A Sp.	hy fa	cardiac or respirator	y errest,	Inte	proximate arval Between serval Between set and Death		
876(ate be hysicia the bun	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as a o	consequence of):								
.O. Both the death by the atternation in year the for it has been suched for it has been suched for it has been suched for it is a such at the such at	Part II. Other significant condition	s contributing to death	out not resulting in	the underlying c	ause giv	en in Part I	. 23b. C	old tobacco use co	ntributa to the	1/		
IS, P. es thet the grand by be detacted by Phy							1	Yes 2 No	3 Probabi	ly 4 Unknown		
Cord requir been s should					8		24a. V	/as an autopsy erformed?	availat	autopsy findings ble prior to etion of cause th?		
The law ate has by page 2 s							- 1	xes 2□No	100	s 2 No		
/ita	25. Was case referred to medical axaminer?	Hospital:			Oth	or.	of Death (Check or					
Vision of Attending Physical death. Setor: After this by the funeral di	1 XYes 2 No 27. Manner of Deeth 1 Natural 5 Pending investigs 3 Suicide 6 Could not determine	28a. Date of Ing (Month, D.	ury 28b.	32 M rm, street, factor	28c. Injur Wor 1	4LI NU	No vehicle	esidence 6 Ooth be how injury occur ed struck a in (Street and Numl Town, State) 7 3	nd compr	oute Number,		
To the Hospital or within 24 hours after within 24 hours after completely filled in Medical Cert	29a. Cartifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of end menner s	of my knowledge of examination an		at the tin	ne, date an pinion, dea	d place, end due to th occurred at the tir	the cause and place,	anner as state and due to the	d. cause(s)		
Tot within 12 Company	29b. Signature and title of certifier	11/	(-)	× 291		e number		29d. Date signe AUG.	7, 200			
The	THEUNOREM	no comprise and a	death (Item 23s)	Penn St	reet	Bal	Ltimore, M	Maryland 2	21201			
State Registrar	31. Date filed (Month, Day, Year) AUG 0 9 200	32. Regist	rar's Signature	Spa	h							

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26527 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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П	Physic	ian	1. Decedent's Nen				177.1						2. Date of D Month		Day	Year				
4	/Medi		NANCY 4a. Fecility Name (mbarl	1			-	4h City To	um or l	AUGUS'					:25 PM		
	Examino		0.112.102.0				no en							oto (4c. County					
L	Funeral Director			-	HOSPIT			T MAI					LAND		ALL	EGAI				
			5. Social Security i	Number	6. Sex 1 ☐ M 2 🖾 F	7. Ag	ge (In yrs. lest birtho	Mor	nder 1 Y	year eys	If Under Hours	24 Hrs. Min.	8. Dete of B	irth ley, Ye	ar)	9. Birth	pleca (S	tate or Foreign		
			216-44		10 W 285 F		56 Yr	S.					SEPT.							
	P .		Usuel Residence of																	
	deeth with the Manyland ms 23a or 28a-f show crivent be notife at at		10e. Stete	10b. County			10c. City, Town of	r Location												
		Director	WV	MINE	RAL		KEYSE	R									11	Yes 2 No		
	or 28	i e	10e. Street and Nu	mber				10	. Zip Co	ode				10g.	Citizen of \	Whet Cou	intry?			
	23a c	0	31 "A"	STREET					267	26					USA					
	ine 2	era	11. Marital Status	OTICELI	12. Was Dec	cedeni	Ever In U.S.	13. Was C			lispanic Orig	oin? (Sr	ecify Yes or N	lo-	_	e - Amer	ican Indi	an.		
020	A LA I D-UUAU d within 72 hours after glene. er then "natural", or fle the "Modical Examine	by Funeral		rled 2 🔀 Marrie	Armed F	orces?	?		specify s 2 🛭				ecify Yes or N Rican, etc.)			ck, While	, etc.			
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		O	17. Father's Neme	(First, Middle, L	ast)						18. Mothe	r's Nam	e (First, Middl	e. Meic				_		
Maryland		Be	EDUARD	TAMEC I	DELIED												NY hpleca (State or Foreignantry) RYLAND 10d. Inside City Limita 1x Yes 2 No untry? rican Indian, b, etc. HITE industry Tip Code) 3 Town, State ID, MD			
7	should Ind Men	To		JAMES I			401. 4	4 111 - 4 4					INE RO							
Ma	12 sho		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) DIANNA LYNN ADCOCK/DAUGHTER 19b. Meiling Address (Street end Number or Rural Route Number, 19b. Meiling Address (Street end Number or Rural Route Number or												_					
	1 and Health em 27 ther tr				DCOCK/DAI	JGH'.					ATE DI	RIVE				8528				
Baltimore,	Page ment o ant: If I				3 □Rem <i>o</i> val from ecify)	Slate	20b. Pleca of D cemetery,	cremetory	or othe	r ple			UG. 8,			- City or Town, State ERLAND, MD				
Balt	permit. Pag Department Important: i any injury o once.		21. Signature of F	uneral Service Li	cens LS	H	T	SN	IITH	F	ss of Facilit	Ĺ HC	ME							
			23a. Part1. Enter I	he diseese, or o	omplications that	cause	d the death. Do not ine.				N STRI		or respiratory		WV	2672		xlmate		
	Physician		shock, or hea	art failure. List o	nly one cause on	each li	ine.			,			,				Interv	al Between		
	/Medical		Immediate Ceuse	(Final																
	Examiner		diseese or condition	on	e. RESI	PIRA	ATORY FAI	LURE									4-5	DAYS		
		h.	,				Due to (or as e cor	nsequence	of):											
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	and tran	Examiner	Sequentially list co	onditions,			Due to (or as e cor	sequence	of):							1				
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68760,		an/Medical	that initiated event resulting in death)	3	c. TOTAL		Due lo (or es e con				WIIII (KD OID.	100	10			BBRO		
99		Per l	resulting in dealth)	L031												ĺ				
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_			Part II Other elani	ficent condition	e contribution to a	loath h	out not resulting in th	o undorh	DG 00110	o ah	on in Bod I		22h Die	Ltobac	00 1100 00	ndelbudo (o the or	una at death?		
0	tha y th	Physici	Total Carlot Organi	noon condition	e continuating to c	ZOZIII D	of not resulting in th	io diluony	ng caus	o giv	on in roll i.									
0	w requires that that been signed by the should be detached												112	Y Yes	Z L No	3 LI Pro	овогу	4 Unknow		
Records,		Completed by											24a. Wa	s en ei formed	utopsy ?	a	vailable	opsy findings prior to n of cause		
Re	The lay ate hes page 2	E	De la company de											1	- 00			•□••		
			OF Was												2 🖾 No	1	⊔ Yes	2□ No		
of Vital	hysician: his certific if director,	25. Was case referred to medical examiner?																		
7	hys his o	2	Hospital:									rsing Ho	me 5 Res	sidence	6 □Oth	er (Speci	ify)			

Division of V

To the Hospital or Attending Physici within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral director. Medical Certification: To

TH

State Registrar

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner as steted.

2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end pieca, and due to the ceuse(s) end manner stated. 29b. Signature end tipe of confilment

5 Pending investigation

6 Could not be determined

1 Yes 2₺ No 27. Menner of Deeth

1 Naturel

2 Accident

4 Homlcide

(Check only one)

3 Suicide

29a. Certifier

28e. Date of Injury (Month, Dey Year)

29c. License number

28b. Time of

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

D-17526

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

AUGUST 10, 2000

21502

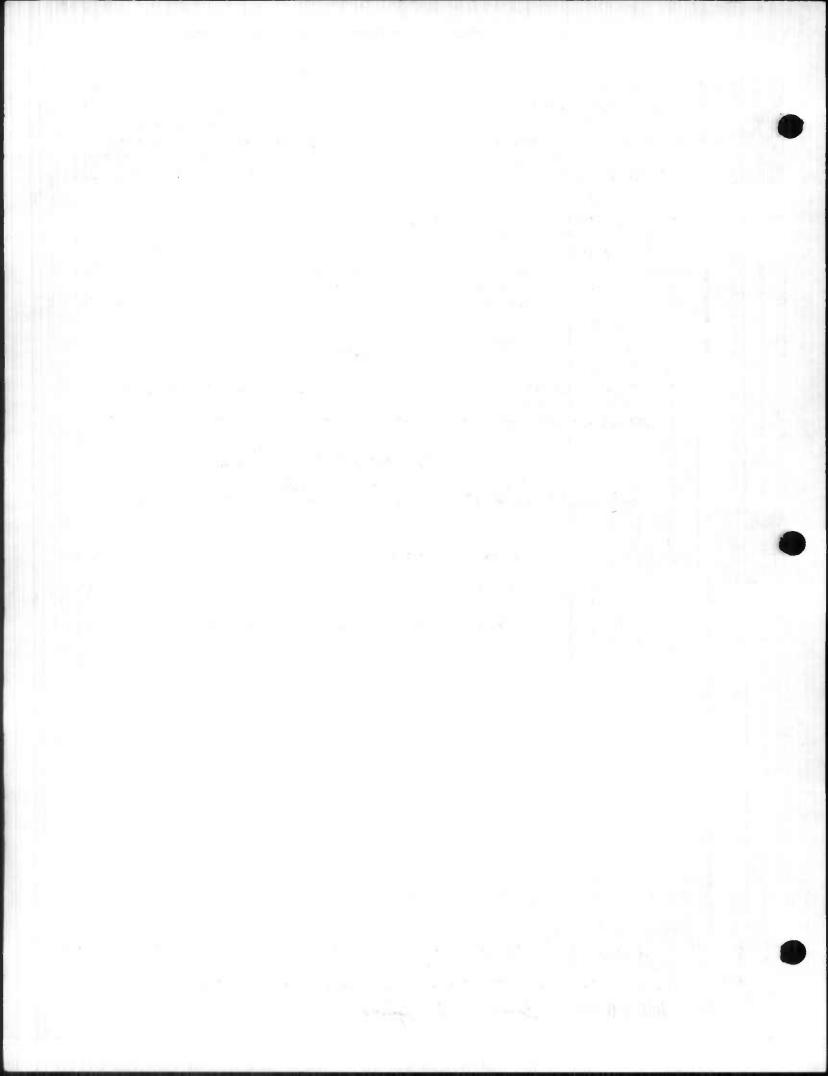
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

JOHN MEHANNA, M.D.
31. Dete filed (Month, Dey, Yeer)
AUG 1 0 2000 902 SETON DRIVE

32. Registrer's Signatur

CUMBERLAND, MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) HARVEY BRANDT 28 12:15 PM 2000 July 4h City Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) The Pines Talbot Genesis ElderCare -Easton If Under 1 Year 8. Dete of Birth (Month, Day, Year)
JUNE 25, 1909 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Sex M 2 F OHIO Months Days Hours Yrs 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 21601 610 DUTCHMANS LANE U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER/ MACHINIST TOOL & DIE MANUFACTURER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) BRANDT CLARA M. BORGNIS 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KIRK L. BRANDT / SON 300 LEISTERS CHURCH RD. WESTMINSTER, MD. 21157 20a. Method of Disposition
1 Burial 2 Cremation 3 Removat from State 20b. Placa of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION CTR. 7-30-00 CHESTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. Joseph M. Ostrowsk: 200 S HARRISON STREET EASTON, MARYLAND 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alzheimers Due to (or as a consequence ot) Due to (or as a consequenca of) Due to (or as e consequence of)

Physician /Medical Examiner

and

the attending physician certificate be

signed by

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After this certificate

by

Completed

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edical Certification:

98

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

234

Heme

natural, or

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filed within 72 hours after

Director

Funeral

by

Completed

traumatic avent, the Medical Examiner must be notified at

ARTHUR

5. Social Security Number

173-07-8803

10e. Street and Number

ARTHUR G.

11. Marital Status

10a. State

Usual Residence of Decedent

Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai the

Immediate Cause (Finet disease or condition resulting in death)

Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

1 Yes 20 No

26. Place of Death (Check only one)

1 Yes 2 No

25.		case	referred	10	medical
	10	Yes	20 No		
27.	Man	nerot	Death		

5 Pending Investigation 6 Could not be 28a. Date of tnjury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

29b. Signeture and title of could

Burgonne

29c. License number

29d. Dele signed (Month, Dey, Year) 23

Kichard

31. Dete tiled (Month, Day, Year) .1111 3 1

30 Name and address of person who

32. Registrar's Signature Tener

completed cause of death (Item 23a) (Type, Print)

607

Dutchmans

DHMH 16 Rev 6/95

Arthur Brandt Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiens important: If item 27 is marked other trupont in Jury or other traumatic avent, trappose.

Box 68760.

P.0.

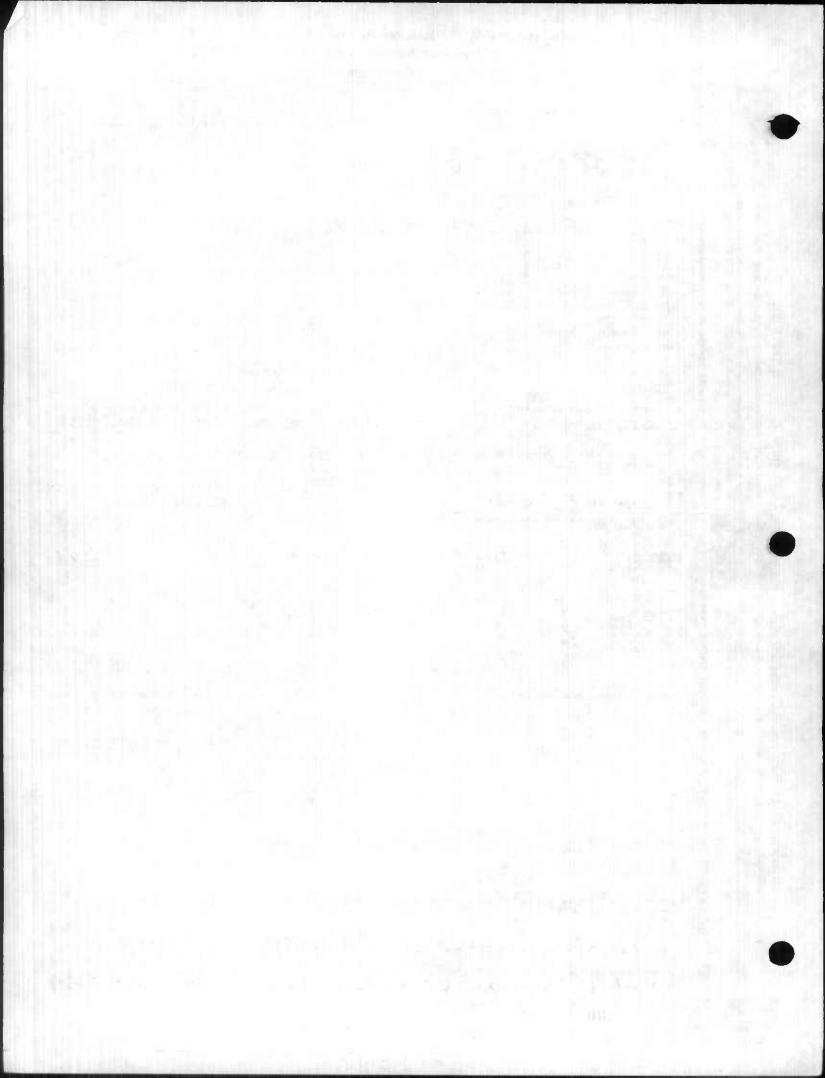
Division of Vital Records.

or Attending P after death.

Director: After t

To the Hospital of within 24 hours a To the Funeral D

State Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 26529

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А	Examiner	4a Facility Name (If not instituti	on, give stre	et and numbe	er)				vo. Ony, 10	WII, OI LC	JOSTION OF DOG	40.00	burity of Death		
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ш	Funeral	5. Social Security Number	6. Sex	2√2 F 7	Age (In yrs. la		Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Di	th ly, Year)	9. Birth	place (St ntry)	ate or Foreign
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	icate be executed physicien end s the burlal-transit		b		Due le /ex										
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	411	30. Name and address of perso	n who comp	eleted cause o	of death (Item	23a) (Type,	Print)								
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State of Maryland / Department of Health and Mental Hygiene

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4 40 = 2		UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, interest only one cause on each line.														
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26531

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Please Type or Print in Biack Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Aug 13, Blake 2000 01:29am Jr. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 611 Kent Avenue Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 X 2 F Yrs. 60 MD Director 216-40-3140 Aug 10, Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yas 2 No Director Allegany Cumberland "natural", or hams 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Kent Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. 13. V Armed Forces? 1 ☐ Wes 2 ☐ No Vietnam Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 1 ☐ Never Merried 2 Merried 1□ Yes 2□ No Baltimore, Maryland 21215-0020 Specify white Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 retired supervisor Tire Company Pages 1 and 2 should be filled hent of Health and Mental Hygic ntt. if Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia M (Ridge) John E. Blake. Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 611 Kent Avenue; Cumberland, MD21502 Charlotte A. Blake Work Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 8/16/ Cumberland, MD 21 Signature of Funeral Service Licenses Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Pert 1. Enter the disease, or compile at ions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical TWO YEARS THENOSCIONOTIC CORONANT ANTENY DUENSE Examiner Due to (or es a consequence ot): Examiner burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Bud Due to (or es e consequence of): Box 68760. physician Physician/Medical Due to (or es a consequenca of): the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yas 28 No 3 Probably 4 Unknown signed t DINGETES Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed INSUFFICIENCY RONAC page 2 s 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No NA Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 2 1 Yes 2 No ome 5 Residence 8 Other (Specify)
28d. Describe how Injury occurred 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident Attending 5 Pending investigation To the Hospital or Attend.
within 24 hours after death.
To the Funeral Director: A death. 1 □ Yes 2 □ No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier w D33417 Aug 14, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MS Moen M.D. 1068 National Highway James R. LaVale MD 21502

DHMH 16 Ray 6/95

State Registrar AUG 1 4 2000

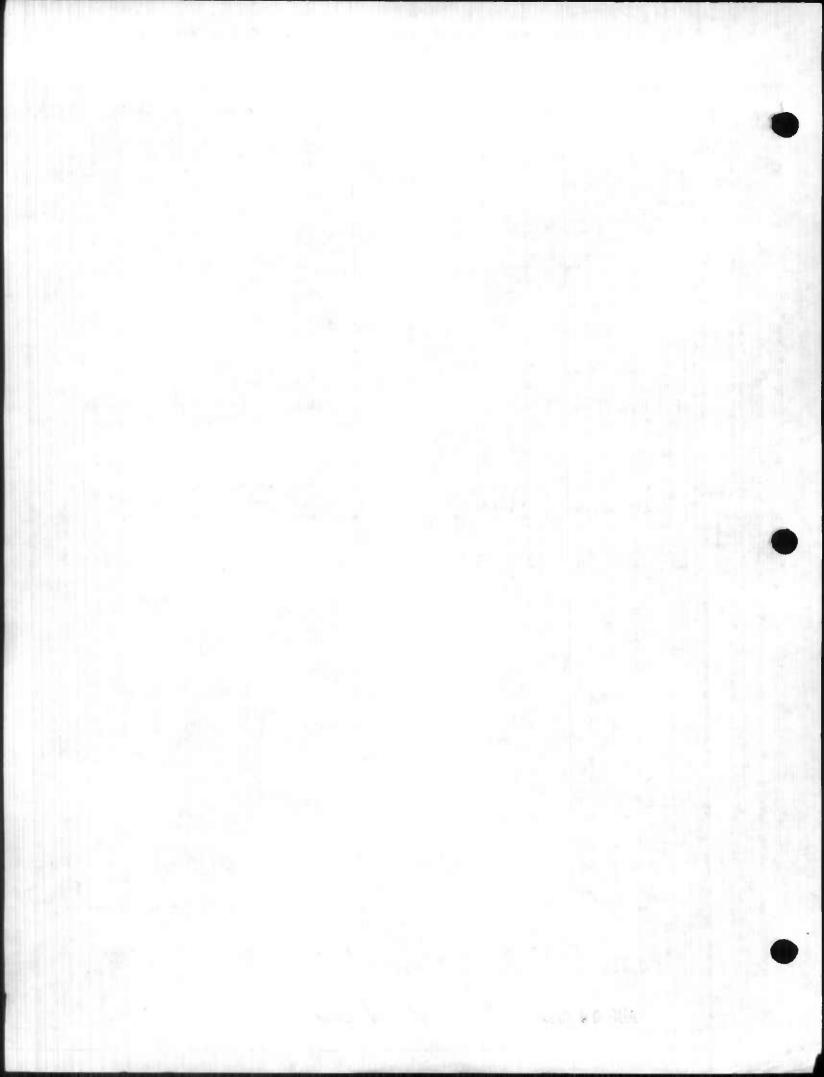
32. Registrar's Signeture

METERNO Emme & spaces

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		State of	Marylan		artmen rtificat			ina N	fental Hy	giene Reg. No.		
	1. Decedent's Name (First, Middle, La	ist)	11-11		190				2. Dete of De	ath	Year	3. Time of Death
Physician /Medical	Elizabeth S	S. Bush							August	Day	2000	1500
Examiner	4e Facility Name (If not institution, given	e street and num	ber)			4	b. City, To	wn, or L	ocation of Death			
	Union Hosp:		Y. T.	- DV	1 1/1 1/1		Elkt			Ceci		
uneral irector		Sex 1□M 2∑F	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months	Deys	If Under a	Min.	8. Date of Bird (Month, Da June 18	y, Year) , 1913	9. Birthp Coun Penns	elace (State or Fore etry) sylvania
	Usual Residenca of Decedent 10a. State 10b. County		10c Cit	ty. Town or Lo	ocation						1	0d. Inside City Lim
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t or 28s-f show be notified at Director	10e. Street and Number				10f. Zip	Code				10a. Citizen of	What Cour	itry?
23s or uni be	108 Hillcrest Ave	enue				9390						
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Framine by Fu	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 Yes 2 If Yes, Give Yeer or De	2 No					, Puerto	rican, etc.)			
ted ted	15. Decedent's E	ducetion		16e. Dece	dent's Usua	10g. Citizen of What Country?	dustry					
Med Med	(Specify only highest grant Elementary/Secondary (0-12)	College (1-	4or 5+)))	Of WORK	ng			
A, the Man	8			Home	emake:	r						Home
riked oth	17. Fether's Neme (First, Middle, Last Kennedy Greer)									ne)	
a ma	19a. Informant's Name/Relationship		hy Di		_							
n 27 her tr	J. Paul. Bush/Hu	sband	last a				Avenu	e, W			_	
or of	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from S	20b. F	Place of Disponentery, cre	matory or o	ne or other plac	e)		Date	20c. Location	· City or To	wn, Stete
The state of	4 Donetion 5 Other (Speci			thodis	t Cem	eter	У				lle,	PA
one one	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921											
edical eminer Examiner	tmmediate Cause (Final disease or condition resulting in death)		dioni	or as a conse	quence of):	el.						Days Years
ician end bunal-transit al Examli	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Car	enous		-	Dise	0.1.					year.
nding physuse as the	Cause (Disease or Injury that initiated events resulting in death) Last	d	Due to (o		quence of):	<i>7</i> /36	rge					
the ath	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	inderlying c	ause giv	en in Part I.		23b. Dld	tobacco use co	ontribute to	the cause of de
Ph Ph									10	Yes 2 No	3 ☐ Pro	bably 4 Unk
shoul etec									24e. Was	an eutopsy ormed?	av	ere eutopsy tindir allable prior to impletion of cause death?
page 2									10	Yes 26 No	1(Yes 2 No
rector, pag	25. Was case referred to medical						26. Place	of Dea	th (Check only	one)		
5 D	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatie	nt 3 DC	OA Oth	er: 4 🗆 Nu	rsing H	ome 5 Resi	dence 6 🗆 Ot	her (Specif	(y)
frer the reservence on:	27. Manner of Death 1 Netural 5 Pending 2 Accident Investigation	28e. Dete o (Month	t Injury , <i>Day Year)</i>	28b. Time o Injury	t 2	28c. Injur Wor	yat k? Yes 2⊡l	No	28d. Describe	how injury occu	rred	
To the Funeral Director: After toompletaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	259. Place	of Injury - At h g, etc. (Special	ome, farm, st	reet, factory	y, office			28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Number,
pletaly fille	29a. Certifier 1 Certifying Pt (Check only one)	nysicien: To the baseliner: On the baseliner	sis of exemine	owledge, deat stion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dee	d plece,	end due to the red et the time,	cause(s) and m dete and place	enner es s and due t	stated. the cause(s)
Comp	29b. Signature and title of cartifier	7			290	c. Licens	e number			29d. Date sign		* .
	Jachdens 105 23322 8.7.200									200)	
71	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. SACHDEN MD, 118 North St. Stute 3B, Elbin MD21921											
	O.Z. SHCHDEVI	UD, IIX	/ Vacia	Sr 0	ule à	50,	E	13 6	n 11(1)21	921		

Registrar

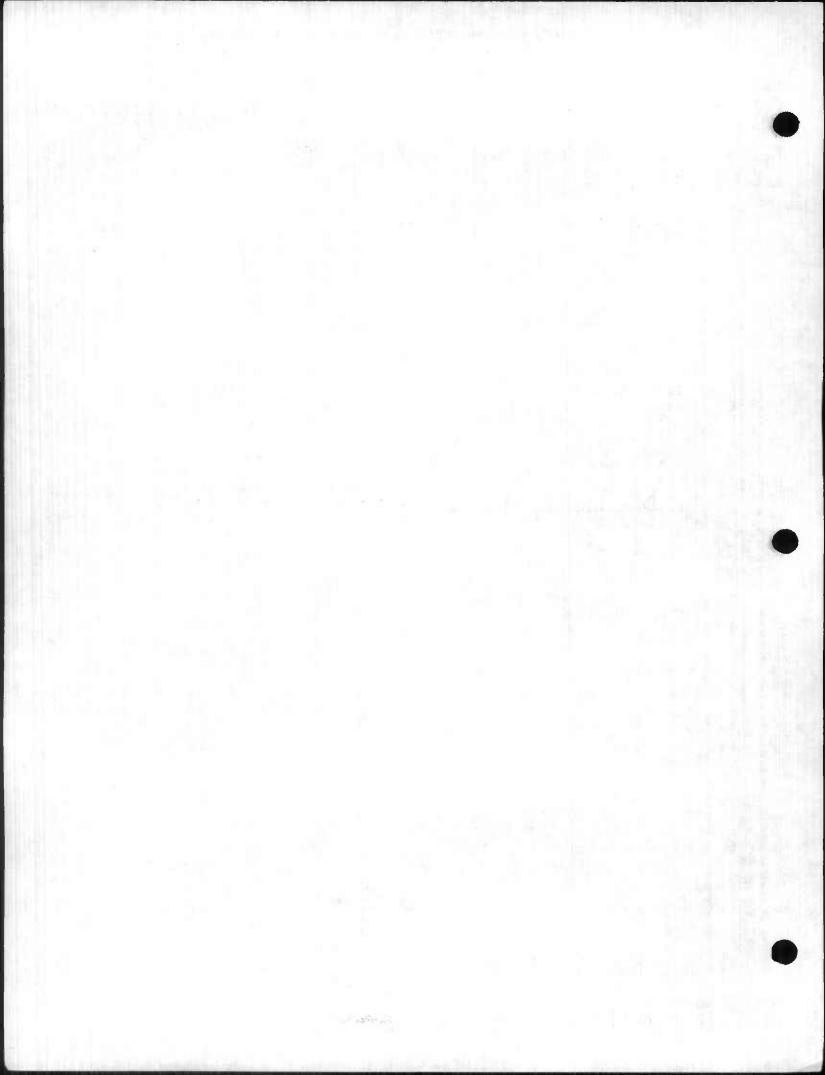


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State of Maryland / Department of Health and Mental Hygiene 00 26534

					Cei	rtificat	e of	Death			Reg. No.			
	1. Decedent's Name (First, Middle, La	ist)							2. Date of De	eeth			3. Tima of Death
Physician	Gilbert	Hamilt	on Barc	lay						Augu	STORY	- 0	Year	0955
/Medical Examiner	4a Fscility Neme (# n	ot institution, giv	e street end nu	ımber)		-	d	4b. City, To	own, or L	ocation of Deal	- 1-0	County of		0,00
LXammer	Union Ho							Elkt	ron		C	ecil		
Funeral	5. Social Security Num	- An	Sex	7. Age (In yrs. la	ast birthdey)	If Under	1 Yeer			8. Dete of Bi			9. Birthol	ece (Stete or Foreig
Funeral Director	222-05-63		1 X M 2□ F	88	Yrs.	Months	Days	Hours	Min.	8. Dete of Bi	Y912			ece (Stete or Foreig ry) syl.vania
	Usual Residence of D	ecedent										1	CIIII	sya. vanita
within 72 hours after death with the Maryland ene. "satural", or items 23e or 28e-1 show he Medical Espansies must be notified at empleted by Funeral Director	10a. State 1	0b. County		10c. City,	, Town or Lo	cation							10	d. Inside City Limit
Varylar f show ed at	Maryland	Cecil.		Ear	levil	le.								1 ☐ Yes 2 ☒ N
vith the Ma t or 28e-f s be notified Director	10e. Street and Numb			230.2		10f. Zip	Code	_	-		100 Citi	zen of Wh	et Count	nv?
E P P	102 Butto		had				919					ted S		
arth arth	105 Bucco			ada a Cara la III d	1401									
r home 234	11. Marital Status		Armed F		5. 13.	Wes Deced	city Cub	ean, Mexica	n, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Black,	White, e	
by F			If Yes, G	2 X No ive		1 ☐ Yes	2 ⋈ No	Specify:				Specify:	Whi	+-
d b	3 🖾 Widowed 4	Divorced	Year or E	Detes:										
ygiene. ser then "naturn rt, tre Medical Completed	(Specify	5. Decedent's E- only highest gra			16a. Dece	dent's Usua kind of wo	al Occu	pation during mos d)	t of worl	king	16b. Ki	nd of Busi	iness/Ind	ustry
n id	Elementery/Second			(1-4or 5+)				od)			Au.	tomob	oile	
and Mental Hygiene. Is marked other than sumatic event, the M	8				As	sembl	er				Mai	nufac	cture	er
Be very	17. Father's Neme (Fig.	rst, Middle, Last)					18. Moth	er's Nam	ne (First, Middle	, Maiden	Sumeme))	
Menti priked To E	George Ba	rclay						Jane	ette	Wilson				
if Health and Mental Hygiene. Item 27 is merited other than "natural", or items 23s or 28s-1 shoother 27 is merited other traumatic event, the Medical Expresser must be notified at other traumatic event, the Medical Expresser must be notified as	19a. Informent's Nam	e/Relationship (Type, Print)		19b. Mallin	ng Address	(Stree	t end Numb	er or Ru	ral Route Numb	er, City o	r Town, S	tete, Zip	Code)
ealth an 27 is	D. Elaine	Barclay	/Niece	THE RES	103 Bu	tton	wood	Road	, Ear	cleville	e, Ma	rylar	nd 21	1919
Department of Health Important: If Hem 27 any injury or other tr once.	20a. Method of Dispos	ition	77 n. 15.	20b. Pts	ace of Dispo	sition (Ner	ne of			Date	20c. Lo	cation - C	ity or Tov	wn, State
Department of important: If he any injury or o once.	1 ☐ Burial 2 🔀			State HOC	metery, cret	n Cre	mat	ory		/17/00	77 . 3			
tangle of the state of the stat	4 Donetion 5				pany					3/17/00		essi	n, De	elaware
npor npor ny ir	21. Signature of Fune	rel Service Lice	nsee		H	Name an icks l	nd Addro Home	ess of Facili	uner	rals, P	.A.			
2599	Day.		2 N	Cashes	1	03 W.	Sto	ckton	St.,	Elkton	, Mar	ylan	d 21	921
	23a. Pert1. Enter the shock, or heart f	disease, or com	plications that	ceused the death.	Do not ent	er the mod	te of dy	ng, such es	cardiac	or respiratory	arrest,			Approximate
ysician	Shock, or heart i	alture. Cist Only	One cause on	Baci ille.									1	Interval Between Onset end Death
Medical	Immediete Cause (Fir	net	Ka	Ulumo.	nin								1	n-
aminer	disease or condition resulting in death)		a										1	veys.
e e			D		es a consec	(uence of):							1	110.
nsit nin			b	mont									1	years
in and hal-transit Examiner	Sequentially list condi	tions, ediate		Due to (or	es a consec	quence of):							į	
ling physician and e as the bunal-transit Medical Examir	Cause (Disease or init	ing ury	c											
ing physicie e as the bu Medical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):													
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attendin I for use			u.										1	
of by the attenderached for us	Part II. Other significa	nt conditions	contributing to d	leath but not resul	ting in the u	nderlying c	ause gi	ven in Part	l.	23b. Did	tobacco	use conti	ribute to	the cause of deat
ed by the detached	Sam	0)								10	Yes 2	□ No 3	3 Prob	ably 4 Unkno
be del	Oep.	315				- 23		-1						
ald by											en eutop	osy	24b. We	re autopsy finding
should should leted										perf	ormed?		соп	npletion of cause
sate has been s page 2 should Completed													OI C	leeth?
page , page Com					31/07					10	Yes 2	No	1 🗆	Yes 2□ No
rector, pag	25. Wes case referred examiner?	to medicat						26. Place	e of Dee	th (Check only	one)			
al dire	1 ☐ Yes 2 ☑ No		Hospitat:	Inpatient 2 E	R/Outpetier	nt 3□ DC	DA Ot	her: 4 N	ursing H	ome 5 Res	idence (6 Other	(Specify)
ter then the nera	27. Menner of Death	5 Pending	28a. Date (Mon	of Injury oth, Dey Year)	28b. Time of Injury	1 2	28c. Inju	ry at		28d. Describe	how injur	y occurred	d	
the fu	2 Accident	investigation			,,	M		Yes 2	No					
d in by the funer.	3 ☐ Suicide 4 ☐ HomicIde	Could not b	288. Place	of Injury - At hon	ne, ferm, str	eet, factory	y, office			28f. Location	(Street en	d Number	or Rural	Route Number,
al Director: After od in by the funer Certification:	4 LI Homicide		Dulid	ing, etc. (Specify)						City or To	WII, SIBIB	"		
To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1	Cartifying Ph	vaician: To the	best of my know	dedge deet	occurred	at the ti	me date ar	nd place	and due to the	cause(s)	and men	ner es et	nted
he Funer pletely fill edical	(Check only 2[Medical Exam	niner: On the b	easis of examination	on end/or in	vestigation	, in my	opinion, dee	eth occur	rred at the time,	dete end	plece, an	d due to	the cause(s)
To the Funeral completely filled	29b. Signature end titl	a of Abrillian	and man	310100.		200	Licen	se number			29d Det	te signed	/Month (Tev Veer)
28	250. Signature end titl		Lev SI	MID								-		
		0-0-0-					12:	3322			8	. 16.	00	
	30. Neme and address	of person who	completed caus	se of death (ttem ;	23a) (Type,	Print)	0) pm	20 7	0000	10-	,		
	S.S. SAC	HOEV	MD.	se of death (from :	th St	Suite	3/3	, te	Re	n 11/1/2	142	1.		
State	31. Dete filed (Month,		32. F											
			hes	wa	4	lon.	16/							
State Registrar	31. Dete filed (Month, AUG 1	7 2000	Seel 32. F	Registrer's Signetu	G.	Spou	6							

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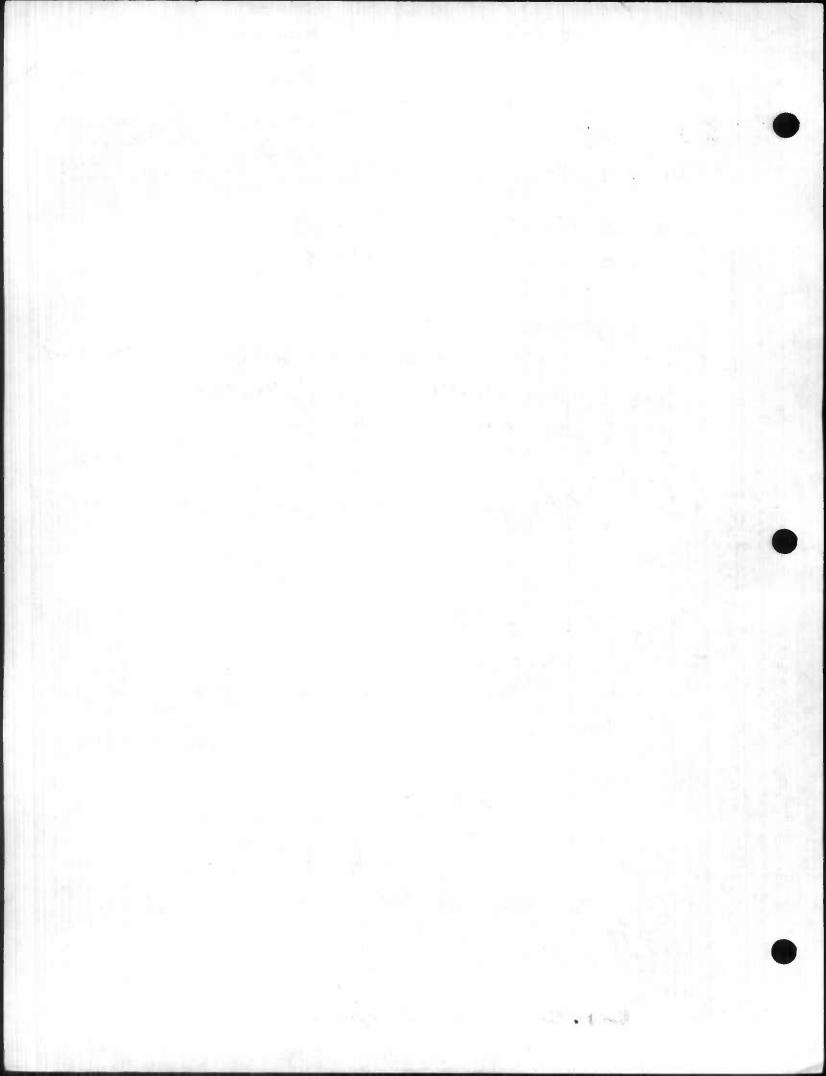
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State of Maryland / Department of He

epartment of Health and Mental Hygien

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AMEND I	TEMS: #23 PART	I, 27 PER ME	CO Certifica	te of Death		eg. No.	0 6	0000
Physician	1. Decedent's Name (First, Middle,	Last) P 1	HYLAC	V	2. Dete of Dea Month	Day	Year	Time of Death
/Medical	JEKEMI	7 1. C	HYLAL		August	4c. County		4:12 A.
Examiner		nion Hospital		Elk		4c. County		
		Sex 7. Age (In yrs.	last birthday) If Und	er 1 Year If Under 24 Hr			9 Birtholace	State or Forei
Funeral Director	188-34-0590	12M 20F 57	Yrs. Months	Days Hours Min	8. Date of Birth (Month, Dey OCT: 15	1942	9. Birthplace (Country)	Pa.
	Usual Residenca of Decedent					, , , , ,		
death with the Maryland ms 23s or 28s-f show r must be mortised at ners! Director	10a. State 10b. County	10c. Ci	ty, Town or Location					side City Lim
28e-1 s	Ta. Mon	Tgomery C	OLLEge	VILLE				PYes 2□1
iner must be notified at	10e. Street and Number	0,00	fof. Z	ip Code	1	Og. Citizen of V	Vhet Country?	
23.8	181 8140	e C Pike	1	9426		Uis	i A.	
	11. Merital Status	12. Was Decedent Ever in U Armed Forces?	I,S. 13. Was Dec	edent of Hispanic Origin? (ecity Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - American Inc ck, While, etc.	man,
>		1 Pres 2 No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify	1.1W.	to
natural deted b				uel Occupation		16b. Kind of Bu	usiness/Industry	16
	(Specify only highest	grade completed)	(Give kind of w	uel Occupation ork done during most of wo use retired)	orking		1	- 1
then.	Elementery/Secondery (0-12)	College (1-4or 5+)	Communi	CATION SU	Pervisor	Mu	Turk 1	Tuds
T S S	17. Father's Name (First, Middle, La	st)		18. Mother's Ne	eme (First, Middle,	Maiden Sumem	ne) 0	L
Menta To B	Leo Theo	dore Chylac	CK	CATI	heriNC 1	MAGE	Pe7	e15
th and Mer 7 le marke traumatic	19a. Informent's Name/Relationship	(Type, Print)	19b. Meiling Addre	ss (Street end Number or F	Rural Route Numbe	r, City or Town,	Stete, Zip Code	
n 27	MONA EILEEN	ICH-12ACK-WIF	£ 781 6	ravel Pike	e COLL	egevil	le YA.	1942
M Hor	20a. Method of Disposition 1 ☑ Buriet 2 ☐ Cremation 3		Place of Disposition (Notemetery, cremetery of	other place)	Dete	20 Location -	City or Town, S	tate
	4 Donation 5 Other (Spe		BURALA	equestus luth	8/10/00	TIA	Ple Ti	A.
Departmen Important: any Injury	21. Signature of remarks Service Vic	censed	22. Name	Address of Facility	, ,,			
20529	XXX	40	Bee	- funeral	Hore	2540	E.MAI	IN S
	23a. Part1. Enter the Visease, or co shock, or heart tayure. List on	omplications that caused the deally one cause on each line.	th. Do not enter the me	ode of dying, such as cardio	ac or respiretory ar	rest,	Inter	roximete val Between
hysician							Ons	et and Death
/Medical xaminer	tmmediate Ceuse (Final disease or condition resulting in death)	ATHEROSCI	EROTIC C	ARDIOVASCU	LAR DIS.	EASE		
THE STATE OF		Due to (or es e consequence o):			1	
n and ial-transit		b						
al-trar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as e consequence o):				
		C. Due to /	or as a consequence of	1.				
0 0 0	resulting in death) Last	7) 0) 0) 0	7 43 4 55 13 GQ 56 100 C	,				
Ç 3 E		d						
ed by the attendate of the detached for u	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given In Part I.	23b. Dfd t	obacco use co	ntribute to the	cause of de
by the		AND THE RESIDENCE			101	/ss 2 No	3 Probably	4 Unkr
>					- 1			
been sign should be					24a. Wes	an autopsy med?	24b. Were as available	e prior to
2 st 0							of death	tion of cause
ate has page 2					1 to	es 2 No	10 Yes	s 2□No
certificate rector. pag				26. Place of D	eeth (Check only o	ne)		
9 0 D	1 XYes 2 No	Hospital: 1 ☐ Inpatient 2√2	ER/Outpatient 3 1		Home 5 ☐ Resid	lence 6 Oth	ner (Specity)	
After the funeral		28a. Date of tnjury (Month, Dey Year)	28b. Time of Injury	28c. tnjury at Work?	28d. Describe h	ow injury occur	red	
or after death. I Director: After to led in by the funeraction: Certification:	2 Accident Investiger	l he	M	1 Yes 2 No				
frar d in by	4 Homicide determine	ed 28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact (fy)	ory, office	28f. Location (S		ber or Rural Rou	ite Number,
within 24 hours after To the Funeral Dir- completely filled in Medical Cert	200 Contilion (C) Contilion	Dr Labor To the boot of multiple	and deep death assume	d at the time, data and class	an and due to the	avec(a) and m	anner en etated	
n 24 hound he Funer pletaly fill	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kno raminer: On the bests of examine and menner stated.						
within 24 hours after death, within 24 hours after death, To the Funerel Director: A completely filled in by the fi	29b. Signature and the of certifier	and mornior states.	2	9c. License number		29d. Date signe	d (Month, Dey,	Year)
- 3 - 5	5/10	11 11.		O.C.M.E.		7	not 7	2000
	30. Name and address of person wh	no completed cause of geath (Ite	m 23a) (Tuna Brint)	O.C.M.E.		Aug	ust 7,	2000
U				Street Bald	timoro M	ararl and	21201	
State	THENNORE MIKE		111 Penn	Street, Balt	timore, M	aryland	21201	



State Registrar

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		3.13			Certifica	ite of Death	7	Reg.	No.	0	26537				
Physicia	1. Decedent'a Name (Fi				4,710		2. Data Mor	a of Death	Day	Year	3. Tima of Death				
Physicia: /Medica	Marv	E	Elizabet	h Day	7is		AU	GUST	8 2	000	5:10 AM				
Examine	4a Facility Name (If not	institution, giv	re street end numbe	r)		4b. City, To	own, or Location of	of Death	4c. County	of Death					
TALL L	lemorial Hos				u t il William	Cumber ler 1 Yaar II Unde	land	1 2	Allega	iny					
Funeral Director	5. Social Security Numb 214-07-208	39	Sax 7. A	Aga (In yrs. last b	Yrs. Month		Min. Feb	e of Birth orth, Day, Ye 23,	1913	9. Birthp Coun	lace (Stete or Foreign for) MD				
yland how	Usual Rasidence of Dec 10a. State 10	b. County		10c. City, Tox	vn or Location					1	0d. Inside City Limits				
or 28a-f a	PA	Bedfo	ord	I	Bedford	i			10'						
er death with the Maryla Herne 23s or 28s-! shor net axist, be notified at	10e. Street and Number 936 Lake (Road		10f. 2	Zip Code 155	22		Citizen of W	/hat Coun	ntry?				
	11. Maritai Status Never Marriad Widowed 4		12. Was Deceder Armed Forces 1 Yes If Yes, Give Year or Dates	s?] No		edeni of Hispanic Or becify Cuban, Mexica 2 No Specify		s or No- etc.)	Biacl	- Americ k, White, white	etc.				
72 ho	15. (Specify o	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during m life. Do NOT use retired)							. Kind of Bu	siness/Inc	dustry				
1 21215-0020 ed within 72 hours at ypiene. ner then "neturel", or 4, the Medical Exam	Elementary/Secondar 12	y (0-12)	College (1-4o	r5+)	inning			tex	xtile						
	17. Father's Name (Firs	t, Middle, Last)	1-			er's Name (First,			e)					
/lar	William F	. Davi	s			Rebe	Profi	fitt)							
Maryland od 2 should be file sith and Mental Hy 27 is merked other r traumatic event	19a. Informant's Name	is	(Type, Print)	129	b. Mailing Addre	ss (Street and Numb Avenue	S.W.;	Route Number, City or Town, State, Zip Code) .; Cumberland MD 21502							
Ore, 18	20a. Method of Disposit		Removal from Stal	nomati	of Disposition (A	lema of r othar plece)	Dete	20c	Location -	City or To	wn, State				
L. Pages 1 triant of Hi tant: If then tury or oth	4 Donation 5				Memoria	al Park	8/10	/ Ci	ımber	land	d, MD				
Ball Semit my in	21. Signature of Funera	1. Signature of Funeral Service Licansee Scarpe 1ddress of Funeral Home, P.A. Cumberland, MD 21502													
	yan	00+													
Bloodston	23a. Part1 Enter the di shoot, or heart fai	lure. List only	one cause on each	ed the death. Do line.	not enter the m	ode of dying, such as	s cardiac or raspir	atory arrest,			Approximate Interval Between Onset and Death				
Physician /Medical	tmmediate Cause (Fina	nt .									2 DAYS				
Examiner	disease or condition resulting in death) a. ACUTE CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):														
7 ==															
cate be executed physician and site burial-transit	Sequentially list conditi	ons,	D	Due to (or es a	consequence o	1):				1					
60, burial		o d	c												
0 = - "	that initiated events resulting in death) Last			Due to (or as a	consequence of	f):				1					
Box eath certi			d												
O. BOX	Part II. Other significan	t conditions	contributing to death	but not resulting	in the underlying	g cause given in Part	1. 23	b. Did tobac	cco uas cor	ntribute to	the cause of death?				
. ± 50								1 🗆 Yss	2 No	3 Proi	bably 4 Unknow				
S the second	CAD	Tipes I							/						
required should	DEMENTIA	-	NAME OF				24	e. Wes en e performed		av:	ere autopsy findings allable prior to mpletion of cause death?				
I Rec Tha law ate has b								1 ☐ Yes	2 No		Yes 2□ No				
Vital F	25. Was case referred t	o medical				26. Ptec	ce of Deeth (Chec	k only one)	/	1					
- 5 <u>0</u> 5				tient 2 ER/C	utpetient 3	DOA Other: 4 N	lursing Home 5	Residence	a 6 DOth	er (Specif	y)				
C B B B		Pending	28a. Date of In (Month, E	ljury Dey Year) 28b.	Time of Injury	28c. Injury at Work?		scribe how i	njury occurr	red					
Vision Attending r death. ector: Afte	2 Accident 3 Suicide 6	investigatio	NO.		М	1 Yes 2		nation /Stran	t a mel Alcembi	ar or Bur	of Doute Alimber				
Division or Attending after death. Director: After d in by the fune	4 ☐ Homicide	determined	building,	njury - At home, i etc. (Specify)	arm, street, leci	огу, опісв	28f. Loc City	y or Town, S	tete)	er or nura	al Routa Number,				
	27. Maryer of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Des 28d. Des														
ithin 2 the xmple	and manner stated. 29b. Signature and title of commer 29c. License number								Date signer	d (Month.	Day, Year)				
F3F8		4	0 -		In E			August 8, 20							
/	30. Nama and address	of person who	pompleted cause of	death (Item 22s)	(Type Print)	D0033280		1	ingu	8.					
nus						TNO CONT	TDT								
State	GUPTA, SUNI	ay. Year	22. Regis	strar's Signature	T BUILD	ING, CUMB	EKLAND,	MARYLA	NĐ —						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dev Vear **Physician** AUGUST 12 2000 1:15 P.M OLIVE FRANCES DAVIS /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND CUMBERLAND NURSING HOME If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□ M 21 F 98 218-68-2712 Yrs Director JAN 31 1902 MARYLAND Usual Residence of Decedent the Marylend 10a State 10h County 10c. City, Town or Location 10d Inside City Limits 28a-f ahow the Medical Examiner must be notified at ALLEGANY CUMBERLAND 1 K Yes 2 No Director MARYLAND 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? *natural", or items 23a or U.S.A. 21502 220 SOMERVILLE AVE. Funeral death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Merital Stetus Black, White, etc. filed within 72 hours after. Hygiene. Wher than "natural", or fte 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE py 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER 8 HOME MAKER Pages 1 and 2 should be filed venent of Heelth and Mental Hygient: If Nem 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First Middle Maiden Sumame) Be VIRGINIA D. EYLER WILLIAM U. TWIGG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) BARBARA L. GARLAND 716 GLENMORE STREET CUMBERLAND MARYLAND 21502 SISTER 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stete 20a. Method of Disposition Date cemetary, crametory or other piece) 1 Burial 2 □ Cremation 3 □ Removel Irom Stete permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) TABOR CEMETERY AUGUST 15 2000 CUMBERLAND MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart leilure. List only see cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Myocar disease or condition rasulting in deeth) Examiner Examiner attending physicien and for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be detached 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes page 2 2. No 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 Ves 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) t X Natural 2 ☐ Accident 5 Pending Invastigation 1 Yes 2 No 3 Suicide 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, State) Placa ol Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homloida within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

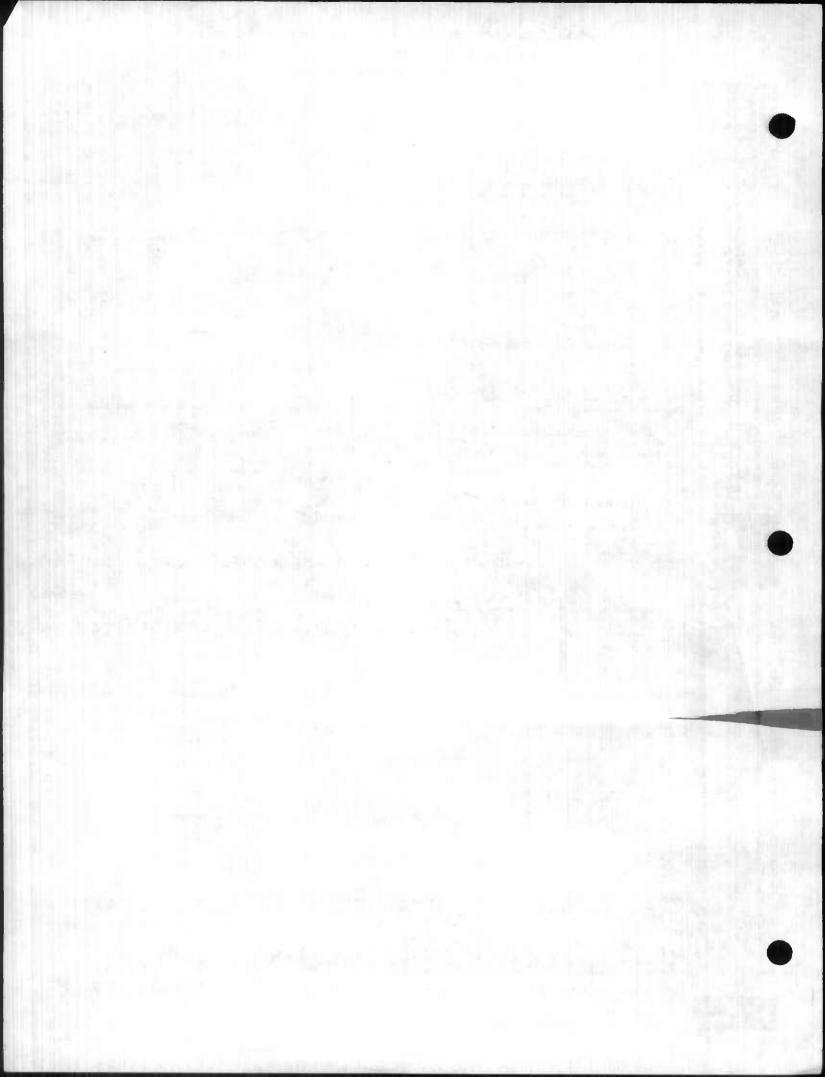
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signeture and III 29c. License number 29d. Dete signed (Month, Day, Year) 3 D 33280 AUGUST 14 2000 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) mas DR SUNIL K. GUPTA 625 KENT AVENUE CUMBERLAND MARYLAND 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 1 4 2000

		State of Maryland	/ Department of F Certificate of	lealth and Mental Hy <i>Death</i>	rgiene Reg. No.	25539			
Physician /Medical	Decedent's Neme (First, Middle, Last)	ELMER G. DO		2. Data of D Month Augus	t 7 2000	3. Time of Death 9:45AM			
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Director	Usual Residence of Decedant 10a. Stete 10b. County	0.	Town or Location	JUL 3	1,1917 Mar	y I a n d 10d. Inside City Limits			
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.0020 hours after death v uval', or froms 29- al Exemples must	1 Never Married 20 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Detas: 4 3 - 4 (10 V 00 VI	lispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, atc.) Specify:	pecify Yes or No- to Rican, atc.) 14. Race - America Bleck, White, et Specify: Whit				
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Box 68760, death certificate be assecuted Medical by a site burial-transit id for use as the burial-transit idean/Medical Examiner	Immediate Cause (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	NY SERC	TENS 10 Nose consequence of):	ACCIDENT OLEMIA		WEEKS YEARS YEARS			
death certification of the second of the sec	Part II. Other significant conditions con		23b. Did tobacco use contributs to the cause of						
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Vital Relicion: The la conflicate ha rector, page	25. Wes case referred to medical			1 = 26. Place of Death (Check only		☐ Yes 2☐ No			
T digital T	27. Manner of Death 1 Neturel 5 Panding 2 Accident investigation		8b. Time of Injury M 1	ner: 4☑ Nursing Homa 5☐ Res		ify)			
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To the Hospital within 24 hours a To the Funeral Completely filled Medical Ce	(Check only 2 Medical Examinate)	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and durant manner stated.							
To the within 2 To the comple	29b. Signeture end title of continu	Millman	29c. Licens	4824(29d. Dele signed (Month	o, Dey, Year)			
State Registrar	30. Name and address of purple who oc DADIEL E, MAKA 31. Data filed (Month, Day, Year) AUG - 8 2000	S DO 506 -	FALEUICO AL	DE EASTON	, UND 2160	0/			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12. NOON August 12 2000 William Sidney Dorsey, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner KIVERSY elCAM If Under 24 Hrs. ARFOR. MO -OKIEN 5. Social Security Number 6 Sex If Under 1 Year 7. Age (In yrs. last birthday) Birthplaca (State or Foreign **Funeral** Min 1 € M 2 □ F Months Days Hours Yrs. 218-18-9059 Director 92 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director 288-1 Harford Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23s. 21 Roosevelt Ave., Apt E-1 21001 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No
If Yes, Give
Year or Detes: 1 □ Never Married 2 □ Merried 1 Yes 24 No Specify: Baltimore, Maryland 21215-0020 Specify: Black by 3 ☐ Widowed 4 [XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Hyglens. College (1-4or 5+) Elementary/Secondary (0-12) Spice Factory Delivery Driver permit. Pages 1 and 2 should be lies.
Department of Health and Mental Hyg.
Important: if Nem 27 is marked other
any Injury or other traumented other 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Albert E. Dorsev Della Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Dorsey, II / Son 8 Ritters Ridge Ct., Ownings Mills, MD 21117 20s. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Dother (Specify) Berkley Cemetery 8/17/00 Darlington, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa M. Scott Funeral Services disa Scott 552 Lewis St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ician and burlei-transit The law requires that the deeth certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): physician as the burlet Box 68760, Physician/Medical Due to (or as e consequence of) 080 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 1 ☐ Yes 💥 No or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 MNatural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 200 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con 7RE 101 E. ROAD BelAiR 21015 WhEEL MJ LIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** Leah Elizabeth Doll 16, 2000 August 06:00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Nursing Center E1kton Ceci If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplace (State or Foreign Country) **Funeral** Days 1□M 2⊠F Months Yrs Director 180-03-6747 93 December 5,1906 Pennsylvania Usual Residence of Deceden 10e State 10b. County 10c. City. Town or Location tOd. Inside City Limits show 1 ☐ Yes 2 No Directo 288-1 Maryland Ceci1 E1kton 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? "natural", or lients 23a or 48 Dell Lane 21921 United States 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: 4 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygien Important: If them 27 is marked other th any Injury or other traumetic server. Silk Weaver 8 Textile 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be James R. Schlegelmilch Elizabeth Koller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Anna Mary Kreiser / Daughter 48 Dell Lane, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 19, Silverspring, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Silverspring Cemetery Pennsylvania 2000 21. Signature of Funeral Service Lie 22. Name and Address of Fecility Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Korachomelmona 3 days Examine Due to (or as a consequence of): Examiner Kenal Jauline -swks ettending physician and for use as the burlel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 4-5 WKS P.O. Box 68760, erelos Vaccular acciden Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yea 2 No 3 Probably 4 Unknown Records. p 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours eiter death.

To the Funeral Director: After this certifica completely illied in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

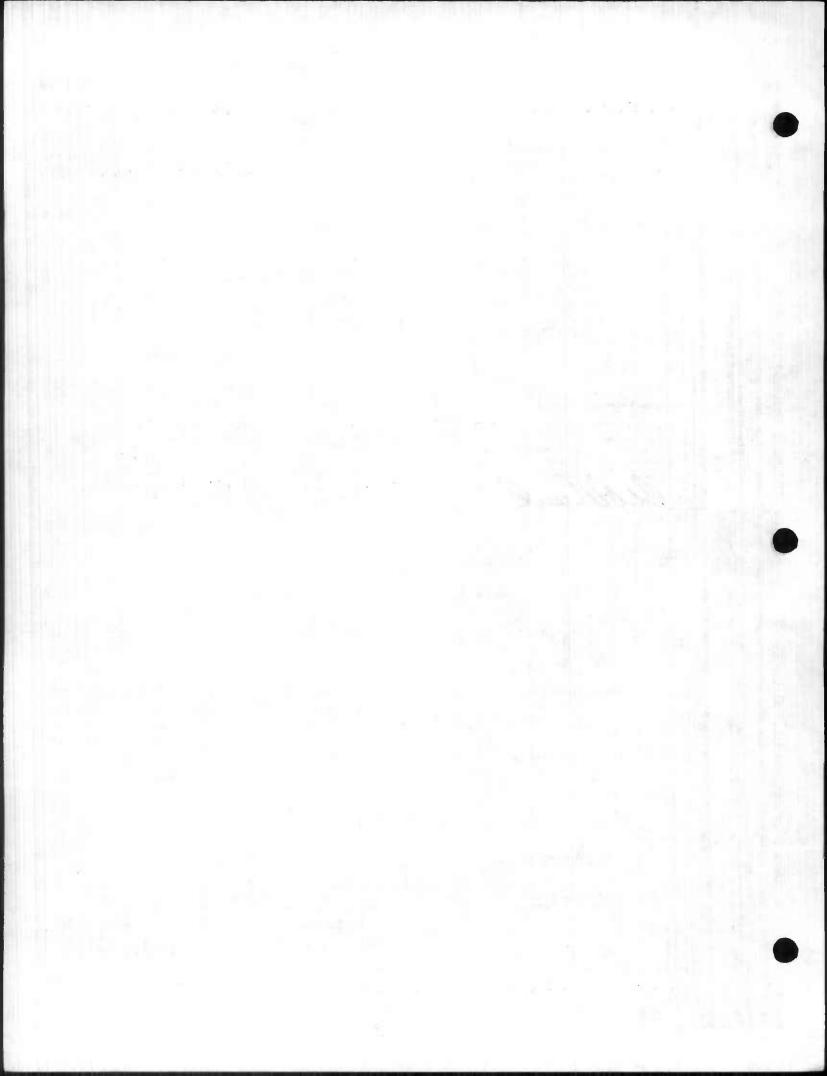
William F. Renzulli,

AUG 1 8 2000

31. Date filed (Month, Day, Year)

14109

MD, 901 Warburton Road, Elkton, Maryland 21921



Amended # 6, Mhs, 8) 14/00, State of Maryland / Department of Health and Mental Hygiene Allegany Co, Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AUGUST 11 2000 7:59 A.M. JUNIOR BENNETT FAZENBAKER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY 10948 GREEN ROW ROAD FROSTBURG If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Yrs. JAN 16 1927 MARYLAND Director 73 215 20 6863 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 Yes 2 No Directo MARYLAND ALLEGANY FROSTBURG hems 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10948 GREEN ROW ROAD 21532 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 Nb1/5/45 If Yes, Give Year or Dates: 12/9/46 1 Never Married 2 Merried natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BURNT BRICK WHEELER BRICK YARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be mant of Health and Mental ARTHUR FAZENBAKER LILLIAN (unknown) To 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . nt of Health a If Item 27 is or other tre THELMA FAZENBAKER / WIFE 10948 GREEN ROW ROAD, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State tant: 4 ☐ Donation 5 ☐ Other (Specify) LAUREL HILL CEMETERY 8/14/00 LAUREL RUN, MOSCOW, MD y Co Licensee 22. Name and Address of Facility or compt SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Chronic Obstructive Pulmonary Disease Years disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 88 080 0 Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1) Yea 2 No 3 Probably 4 Unknown Sign De þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes No 1 ☐ Yes 2 ☐ No certificate of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Yes 2 No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Investigation Division death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 C Homicide ò filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical tely (Check only one) To the Vilhin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of o 29c. License number 2000 Aug D09157 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print))ULS PAUL SNOW, M.D., 124 W. 3RD ST., CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar'a Agnature AUG 1 4 2000 Registrar

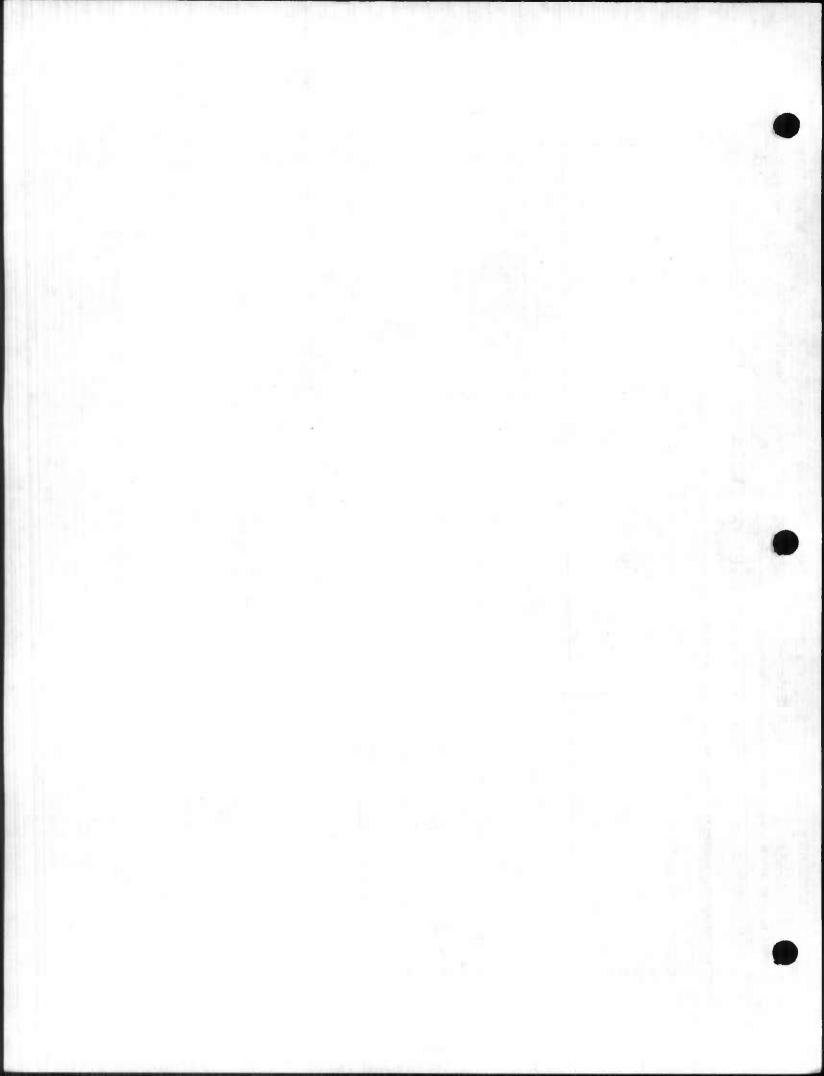
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State of Maryland / Department of Health and Mental Hygiene

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y Name (If not institution, giv	re street and number)	And the			4b. City, To	wn, or Lo	cation of Death	4c. County					
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r's Neme (First, Middle, Last,)				18. Mother's Neme (First, Middle, Maiden Sumeme)								
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rmant's Neme/Raletionship (Type, Print)	19b.	Meiling Addras	s (Street	and Numb	er or Run	el Route Number	City or Town,	Stete, Zip	Code)			
C. Farrall /	Daughter	150)80 Bur	nt S	tore I	Road	Hughesv	ille, M	[aryl	and 20637			
20b. Place of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State													
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fores 1/10	Rd. Charlotte Hall, MD 2												
A, or haert failure. List only	plications that caused one cause on each lin	the de ath. Don a.	ot enter the mo	de of dy	ng, such as	cardiac	or respiratory arre	est,		Approximate Interval Between			
Onset and Death													
disaase or condition rasulting in death) Cardlomyopatny													
disaase or condition Cardlomvopathy													
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ally list conditions,		Due to (or es e c	onsequance of):					1				
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that initieted avents a consequence of): resulting in deeth) Last													
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her significant conditions of	contributing to death bu	t not resulting In	the underlying	cause gi	ven in Pert	1.	23b. Did tobacco use contribute to the cause of						
							1 Yes 2 No 3 Probably 4 Un						
							24a. Wes e	n eutopsy	av	ere autopsy findings vailable prior to			
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inar? 'ex XXX No	Hospitel: 1 ☐ Inpatier	4 0 DED/O	patient 3 0	OA Ot	han		ma XXX Kasida		or /Consi	(6 c)			
ar of Death				28c. Inju		ursing Ho	28d. Dascribe ho			(1)			
aturel 5 Pending investigatio	28e. Date of Injury (Month, Day	Year) In	jury M		rk?]Yas 2□	No							
Suicida 6 Could not b		ry - At home fer					28f. Location (St	reet and Numb	oer or Run	rel Route Number,			
fornicida determined	building, etc.	ry - At home, fer (Specify)	in, otrock, rook	,, 0,,,00			City or Town	, Stete)					
iliar - +F3 Andituda - Di	numbers. To the best of	l — l a avida da a	dooth conven	d at the fi	ma data ar	el alaca	and due to the or	ouncie) and my		atatad			
ck only 2 Medical Exar	miner: On the basis of	examinetion and	Vor invastigation	n, in my	opinion, des	th occur	red at tha time, d	ata and place,	and due t	to the cause(s)			
	end menner ster	eu.	12	ac Licas	sa numbar		2	9d Date since	d (Month	Day Yearl			
1/01/11	Y M. T	00.	2										
D28352 August 8, 2									2000				
and eddress of person who	completed cause of de	ath (Item 23a) (Type, Print)										
	. MD . P	Q. Box	1703	J.a	Pla	ta.	MD 20	646					
shan Mathur								2.70					
0) 0	stura and fitte of certifier Active and eddress of person who	sk only 2 Medical Examiner: On the basis of end menner stell stura and title of certifier Author W Medical Examiner: On the basis of end menner stell sturies and title of certifier Author W Medical Examiner: On the basis of end	And eddress of person who completed cause of death (Item 23a) (storily 2 Medical Examiner: On the basis of examinetion and/or invastigation and title of certifier Authority Authority Authority and eddress of person who completed cause of death (Item 23a) (Type, Print) han Mathur, MD., P.O. Box 1703	storily 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my end menner steted. 29c. Licen D2 and eddress of person who completed cause of death (Item 23a) (Type, Print) han Mathur, MD., P.O. Box 1703, La	the only 2 medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, descend menner steted. 29c. License number D28352 and eddress of person who completed cause of death (Item 23a) (Type, Print) han Mathur, MD., P.O. Box 1703, La Pla	and eddress of person who completed cause of death (Item 23a) (Type, Print) han Mathur, MD., P.O. Box 1703, La Plata.	And eddress of person who completed cause of death (Item 23a) (Type, Print)	the only 2 medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, end menner steted. 29c. License number 29d. Date signe 29c. License number D28352 Augus and eddress of person who completed cause of death (Item 23a) (Type, Print) han Mathur, MD., P.O. Box 1703, La Plata, MD 20646	August 8, and eddress of person who completed cause of death (Item 23a) (Type, Print) han Mathur, MD., P.O. Box 1703, La Plata, MD 20646			



State of Maryland / Department of Health and Mental Hygiene

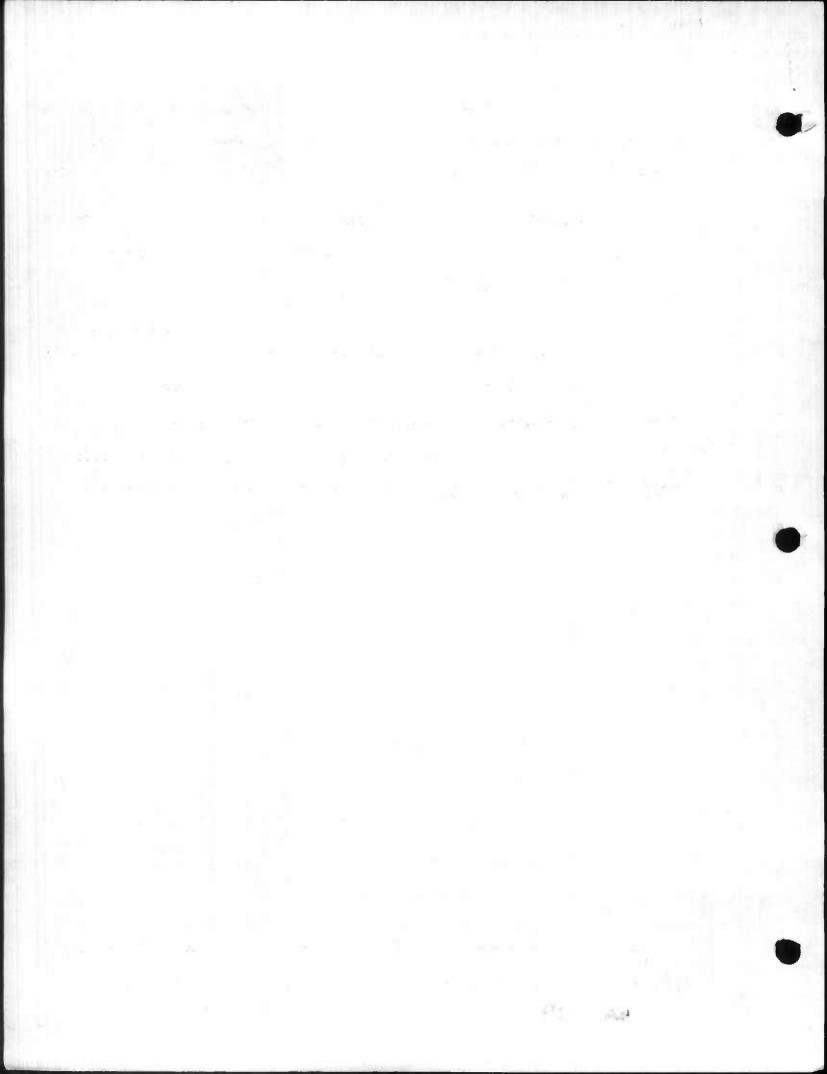
26566 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 5:20 p.m. Juanita Fitch 2000 August /Medical 4b. City, Town, or Location of Death 4a. Fecliity Neme (If not institution, giva street and number) 4c. County of Death **Examiner** 355 Congress Avenue, Apartment No. 1 Havre ue St. Bete of Birth (Month, Dey, Year)
June 28, 1929 Havre de Grace Harford If Under 1 Year 9. Birthpiaca (Stata or Foreign Country) West Virginia 5. Sociel Security Number 7. Age (In yrs. last birthdey) Funeral Deys Months 1□M 2XJF 236-50-1795 71 Yrs Director Usuei Residence of Decedant the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at NYYes 2 No Director Maryland Harford Havre de Grace 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 457 Green Street 21078 "natural", or items 23a U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ② No if Yas, Give Yeer or Detes: Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - Amarican Indian, Black, White, etc. 11 Marital Status 72 hours after 1 □ Navar Married 2 □ Married 1 Yes 2 No Specify: Specify: by 3€XWidowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. West Virginia Elementery/Secondary (0-12) Coilege (1-4or 5+) Two Years Public School System Head Start Teacher other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Noah Phillips Belva Murphy 2 19e. Informent's Neme/Reielionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sharon Fitch (daughter) 457 Green Street, Havre de Grace, Maryland 21078 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Baker Cemetery 8/12/00 Aberdeen, Maryland 21. Signeture of Funerei Service Licensee 22. Nema end Addrass of Facility Lee A. Patterson & Son Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hear feiture. List only one ceuse on each line. Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final disaesa or condition resulting in death) METASTATIC Examiner Due to (or es a consequence of): Physician/Medical Examiner CALUNOMA physician and the burial-trans Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) certificate be Dua to (or as a consequence of): 88 attanding p 188 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ADWO þ 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes en autopsy performed? Completed HYPERTENDION peeu page 2 s has certificate 1 Yas 2 No 1 Yas 2 No Physician: 25. Wes case referred to medicel examinar? Be 28. Place of Deeth (Check only one) Hospitei: 1 Yas 2□ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this luneral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury of Attending Plant of the country of Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 ☐ Homicide filled in Hospital of 24 hours e
 Funersi D 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner stated. To the Vithin 2 29b. Signeture end title of certifier 29d, Data signed (Month, Day, Year) DME OCME 2000 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) PNASHUM.D 728 BERAIR M BERAIL MO 21014 Dete filed (Month, Dey, Year) 32. Registrer's Signature State AUG 11 2000 Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760

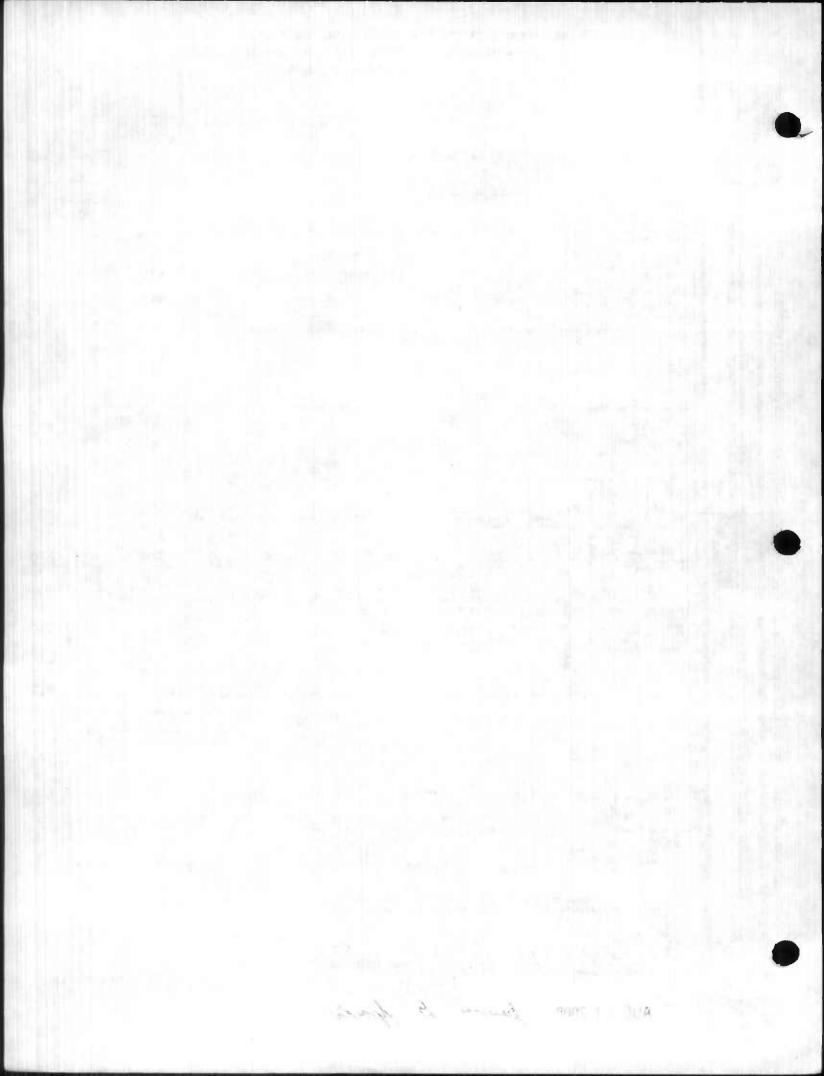
Division of Vital Records, P.O.



State of Maryland / Department of Health and Mental Hygiene

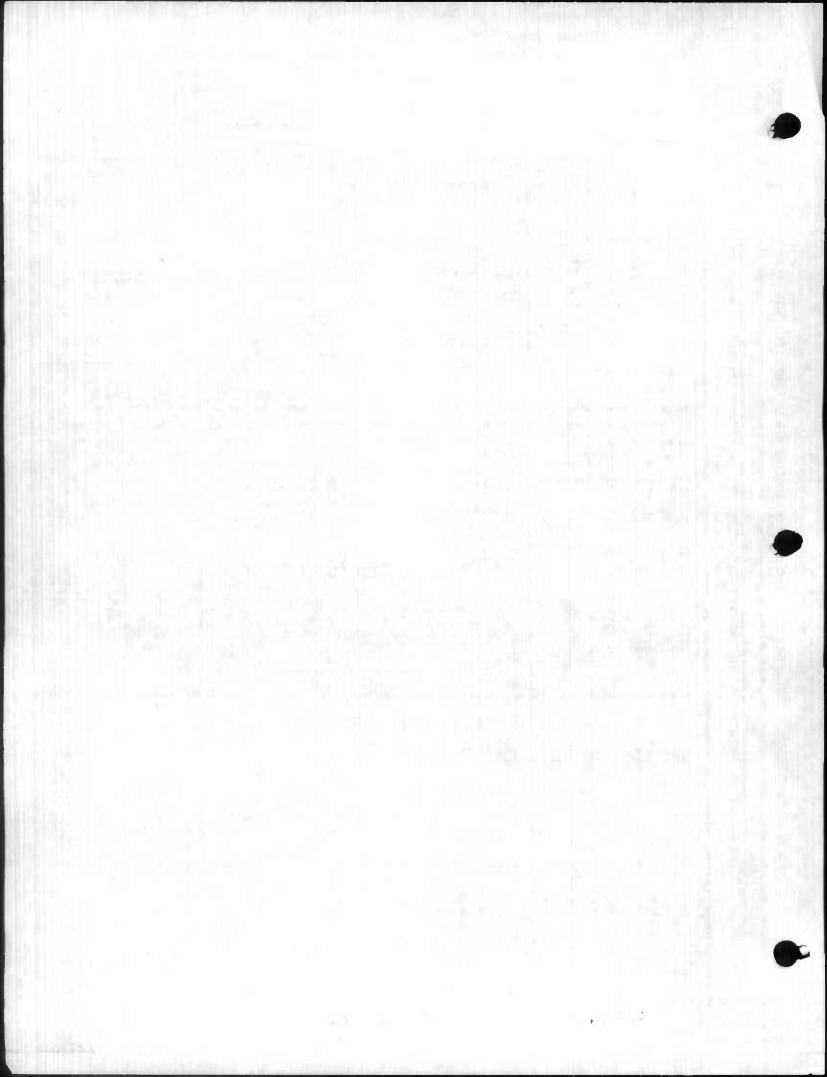
Certificate of Death

					Ce	rtifica	te of	Death			Reg. No.		20010		
		1. Decedent's Neme (First, Middle, L	ast)							2. Dete of De		Voor	3. Time of Death		
		JOHN WILLIAM GR	REEN							AUGUST	10 Dey	2000°	09:00AM		
		4a Facility Name (If not institution, gi	ive street end num.	ber)				4b. City, To	wn, or Lo	ocation of Deat	h 4c. Cou	nty of Deeth			
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Francis		5. Social Security Number 6.	Sex 7	. Age (In yrs.	last birthdey) If Und	er 1 Yeer			8. Dete of Bir	th	9. Birth	plece (Stete or Foreign		
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T THE ST	ПО	7	00000 (1.		I	LABOR	ER		KAISER REFRACTORIE						
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o du pa		CLARENCE GREEN						COI	RA F	AZENBAK	ER				
A DAME	-		(Tyne Print)		19h Meiti	ing Addre	es (Straat	t end Numbe	er or Run	al Route Numb	er City or To	wn Stete Z	in Code)		
Magaga day day fie fred															
San Park			DAUGITER	20h I					,	Date		on - City or 1			
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Page				REST	r LAWN	MEMO	RIAL	GARD	ENS'	12/00	LaVAL	E, MD			
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00.7		shock, or heert failure. List ent	y one ceuse on ee	ch tine.			out or up.	,					Intervel Between Onset and Deeth		
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Examin	er	resulting in deeth)	Due to (or es á consequence of):												
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F P ica	D D	resulting in death) Last	/	Due to (d	or es a conse	quence or);								
Se a	3		l d												
ath ath	<u>a</u>														
. 0 0 %	18/	Part il. Other significant conditions	contributing to dea	ath but not res	sulting in the u	underlying	ceuse gi	ven in Part i		23b. Did	tobacco use	contribute	to the cause of death		
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in the second															
quire or si		Detailed the state of									en autopsy ormed?	24b. V	Vere eutopsy findings weilable prior to		
5 9 8 of 8	et								_	Poli	oimeu :	0	completion of cause of death?		
has has	Ë														
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hysik hysik nis c	10	1 ☐ Yes 2 No	1 ln		ER/Outpetie	int 3□ [DOA O	ner: 4 Nu	irsing Ho	ome 5 Res	idence 6 🗆	Other (Spec	eify)		
	Ë					of	28c. tnju Wo	ry et ork?		28d. Describe	how injury oc	curred			
e fe Billion	atio			,, ,	,,	М		Yes 2	No						
Arto de ty	=	determine	d 259. Piece C	of Injury - At h	ome, ferm, st	treet, fecto	ory, office					um <i>ber or R</i> u	ral Route Number,		
i Dage	- t	4 Homicide	building	g, etc. (Speci	N)					City or 10	wn, Stete)				
plts ours eral	0	29e. Certifier 1x Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as state.									steted				
Hos Pun Fun	edical		2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et and menner stated.							red et the time,	date end ple	ce, end due	to the cause(s)		
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	New Me									29d Date of	aned Alanes	n, Dey, Year)			
		29b. Signeture and title of certifier 29c. License number 29d. Date sign										2			
3	3	May 1	you	050	w		10	47	/	A	UGUST	10.	2000		
		30. Nema and address of person who	completed cause	of death (Ite	m 23a) (Type	, Print)			-			1	- 3		
72	S	CHANG H. A.	A, MD	4	FYACK	1 /	SKRA	CZ.	MR	05TBURE	7, Ma	1.01	532		
	State	31. Date filed (Month, Day, Year)	32. Re	gistrer's Sign	eture/	1	4			1					
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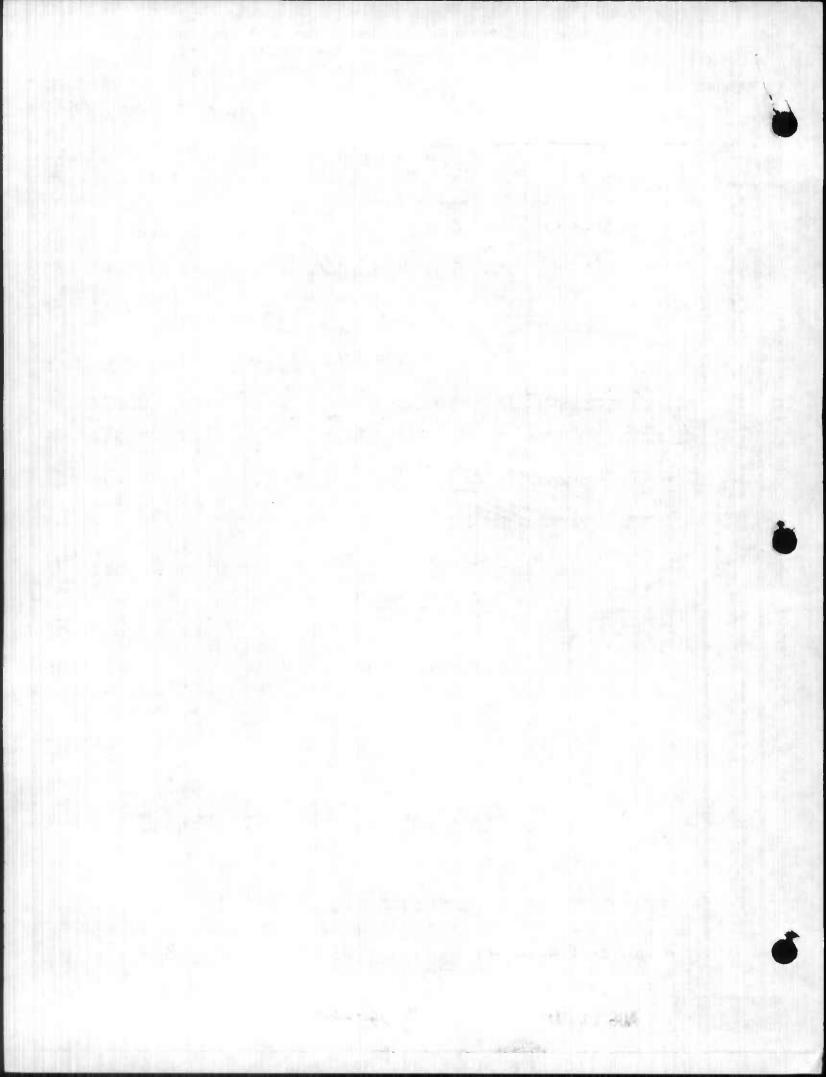


State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death Reg. No.													
		1. Decedent's Nama (First, Middla, Las	t)				2. Data	of Death			3. Tima	of Death			
	Physician	Lovell Ruff	Given				Augu		Day 2	Year 2000	0630	A			
1	/Medical Examiner	4a Facility Nama (If not institution, giva				4b. City, Tow	n, or Location of I		4c. County		0000				
	Examiner	Sunbridge Care C	Carried Control			Elkto	on		Ceci	1					
-	Europal	5. Social Security Number 6. Se		rs. last birthday			4 Hrs. 8. Data	Birth Day, Ye			aca (State	a or Foraign			
	Funeral Director	168-14-2713	□ M 2ÅF 79	Yrs.	Months Day	s Hours	Min. (Monti	16,	1921	Penns					
	pung at a	10a. Stata 10b. County	10c.	City, Town or I	_ocation					10	Od. inside	City Limits			
	vith the Mary t or 28a-f sh be notified.	Maryland Cecil	E	Elkton				1 ☐ Yas							
	death with the Maryland rms 23a or 28=f show rmust be notified at neral Director	10e. Street and Number 1445 Blue Ball Ro	pad		10f. Zip Code 21921		114		Citizen of V						
020	led within 72 hours after death with the Marylan byglene. The than refurel; or florms 23s or 28s-f show the than the facilities must be notified at the Completed by Funeral Director.	11. Marital Status 1 Nevar Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedant Evar in Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas:	n U,S. 13	Was Decedant of If Yas, specify Cu 1 ☐ Yas 2 ☑ No	ban, Mexican,	in? (Specify Yas o Puarto Rican, ato	or No- .)	Biad	a - Amarica sk, Whita, a :: Whi	atc.				
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Maryland 21215-0020	within "rene".	Elementary/Secondary (0-12)	Collega (1-4or 5+)		a kind of work don DO NOT usa ratii ice Manac		or working		Small. Repair		ne				
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an	Mental H Mental H mrked oth artc sven	Bailey Ruff				Beul	lah Weav	er							
2	2 should be end Mental is marked of aumatic av	19a. Informant's Name/Ralationship (7	'vne Print)	19h. Mai	iling Address (Stre	et and Number	or Rural Routa N	umber. C	ity or Town.	Stata. Zip	Coda)				
Z S	and 2 s eith en 27 is i	Otis Steltz/Son	,,,,,,		Castleto										
6	Heelth Heelth Heelth Sther tr	20a. Mathod of Disposition	200	b. Piace of Dist	position (Nama of amatory or other p		Data		Location -						
Baltimore,	permit. Peges 1 and 2 should be filled within Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, in all once. To Be Compl	1 X Buriai 2 Cremation 3 4 Donation 5 Othar (Specify	, P	8/11/	Fawn Grove, 8/11/00 Pennsylvania										
Balt	Dependency mporture in Injury	21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 219													
	20240	Donuede	S. Huber							nd 21					
	Physician /Medical Examiner	23a. Part1. Entar tha disaasa, or comp shock, or haart failura. List only of Immediata Causa (Final disaasa or condition resulting in death)	. Meta:		IC V					NEN	Approxim Interval B Onset an	Batween			
ox 68760,	certificate be assouted rights physician end use as the burial-transit and a company of the comp	Sequentially list conditions, if any, leading to immadiata cause. Enter Undarfying Cause (Disease or Injury that initiated evants rasulting in death) Last													
m	death cer e attendir ed for use	6 - 11 Can - 1 - 161 - 1 - 161					1 001	Di Lacari		1	45				
P.O.	The law requires that the death ce also has been signed by the attendit page 2 should be detached for use Completed by Physician/	Part II. Other eignificant conditions co	RENA(given in Part I.	236.	1 Yes				Unknown			
	be of		·OUVIT		COM						10000000000	#1 #1 To 1			
Vital Records,	w requires been sign should be	ASCVA					24a.	Was an a performe		ava cor	ara autops ailabia pric mpletion o death?				
Re	The law ate has be page 2 s	MBP						1 🗆 Yas	2 DNo		Yes 2	□ No			
ita	certificate rector, pag	25. Was casa refarred to medical axaminar?				26. Piaca	of Death (Check	only ona)							
of	Physician: this certific ral director.	1 Yas 2 No	Hospital: 1 ☐ Inpatiant 2	ER/Outpati	ent 3 DOA	Other: 4 19 Nur	sing Home 5 🗆	Residanc	e 6 Oth	ar (Specify	v)				
ouo	Attending Pt r death. ector: After it by the funera Ification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Invastigation	28a. Data of Injury (Month, Day Year	28b. Time injury	W	juryat /ork? □ Yas 2 □ N		ribe how	injury occur	red					
á	विश्वेद	3 Suicide 6 Could not be determined	28a. Place of Injury - A building, etc. (Spe		ion (Street or Town, S	et and Numb Stata)	per or Rura	l Routa N	um <i>ber</i> ,						
	To the Hospital within 24 hours To the Funeral I completely filled	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	relcian: To the best of my liner: On the basis of exam and manner stated.	knowledge, dea ination and/or	ath occurred at the invastigation, in my	time, date and opinion, deatl	piace, and dua to n occurred at tha	the caus	a(s) end me and place,	anner as st and due to	eted.	e(s)			
	within 2 To the comple	29b. Signature and Note of certifier	. 1		29c. Lica	nsa number)				
		1 Doutho	AL)		A3	0291			8/8	100					
	15	30. Nama and addrass of person who o				Elk+o	n. MD 21	921							
	State	Robert Denitzio, M.D., 111 West High Street, Elkton, MD 21921 31. Data filed (Month, Day, Year) 32. Registrar's Signatura													



	EM #4a 08/11/200 1. Decedent's Nama (First, Middle, L	unty health	rjw Certifi	cate of L	<i>Jeath</i>	2. Data of De			e of Death	
/sician ledical	Irene	GASTON				August		2000 18	50	
aminer	4a Facility Nama (If not institution, gi		LONHOSP:		o. City, Town, or	Location of Deal	th 4c. County	of Death		
eral	5. Social Security Number 6.		. last/birthday) If I	Jnder 1 Yeer	If Under 24 Hrs	8. Dete of Bi	of Birth 9. Birthplace (State or Foreig			
tor	212-22-2828	10M 2ØF 92	7 Yrs. Mo	nths Days	Hours Min.	Month, Di	1908	VIT9,N	A	
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Locatio	n				10d. Inside	City Limi	
to	Delaware New (CASTLE N	ewARK	,				1 🗆 Y	es 2 1 N	
olrec	10e. Street and Number	A /		of. Zip Code			10g. Citizen of V	Whet Country?		
Funeral Director	260 EIRTON	Rd # F6		1971	1		USA	American Indian		
Fun	11. Merital Status 1 Never Merried 2 Married	12. Was Decedent Evar in I Armed Forces?	If Yas	, specify Cuber	spenic Origin? (S n, Mexican, Puer	to Rican, atc.)		e - American Indien ck, White, etc.		
2	3 Widowed 4 □ Divorced	1 Yas 2 No If Yes, Give Yeer or Detes:	101	res 25 No	Specify:		Specify	BlACK	/	
Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Decedent's (Give kind	Usual Occupa of work done d	ition uring most of wo	rking	16b. Kind of Bu	usiness/Industry		
фша	Elementary/Secondary (0-12)	College (1-4or 5+)	House	Kee. A	1110	DOIT	UNIVEX	Tu NG	DE	
Be C	17. Fathar's Nema (First, Middla, Las)	110000	1	18. Mether's Ne	me (First, Middle	, Meiden Sumen	na)		
10	PRICE	WAller			CLAI	e A	JENN!	1-1-2		
	19a. Informant's Neme/Relationship	(Type, Print)	19b. Mailing Ad	Idress (Street e	C T	11/.	ber, City or Town,	Stefe, Zip Code)		
	HRIENE WOOD 20a. Method of Disposition	20b.	Place of Disposition cemetery, cremetor	(Neme of	3//	Date	20c. Location -	City or Town, Stete	,	
	1 Darial 2 Cremation 3 4 Donetion 5 Other (Spec		John 1	em et	0 - 40	1/4/00	NewAR	K DE	-	
DUC.	21. Signeture of Funeral Server	M008	60 22. Ne	me end Addres	s of Facility Co	Ngo FO	INESAL	Home		
a	(4)	100			201	N. BR		Wilm, De	1980	
an	23a. Part i. Enter the Shape or conshock, or heart failure. List only	one cause on each line.	ith. Do not enter the	e mode of dying	j, such es cardia	c or respiretory i	errest,		Between nd Death	
al :	Immediate Caúse (Finat disease or condition	131.50	myscara	T. L	106/200			5 d	aso	
	resulting in death)		(or es a consequenc		- Company			1	-0-	
Examine		b. Couge		I fail	er oc	DO.	1 4	50	ly	
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	or es a consequenc	e of):				5	1000	
dicai	Cause (Disease or Injury that initiated events resulting in death) Last	0.	or es a consequand	e of):					-	
n/Medic		o. Diale	ele me	elhes				30	ye	
Completed by Physician/Me	Pert II. Other algnificant conditions	contributing to death but not re	sulting in the under	vino cause give	en in Part I.	23b. Did	I tobacco use co	ntribute to the cau	ae of dea	
Phys						10	Yea 2010	3 Probably	l 🗌 Unkni	
d by						24e We	s an autopsy	24b. Were autop	sy finding	
lete			31.15			perf	formed?	available pr completion of death?	ior to	
ошь						10	Yes ANO	1 ☐ Yes	2□ No	
Be	25. Wes case referred to medicat examiner?			120		eth (Check only	one)			
10	1 ☐ Yes 2 ☐No 27. Manner of Death		ER/Outpatient 3	DOA Othe	4 LI Nursing I	-	idence 8 Oth			
tion	1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	Injury	28c. Injury Work	res 2 🗆 No	260. Describe	now injury occur	100		
Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - At l building, etc. (Spec	home, farm, street, l	ectory, office		28f. Location City or To	(Street and Numb	per or Rural Routa I	vumber,	
Cer										
edical	29a. Certifier 1 Certifying P (Check only 2 Medicat Exa	hyeiclan: To the best of my kn miner: On the basis of examin and menner steted.	owledge, deeth occ etion end/or investig	urred et the tim gation, in my op	e, date and place linion, death occi	e, end due to the urred at the time	cause(s) and ma , date and plece,	anner es atated. and due to the cau	se(s)	
Me	29b. Signeture and title of certifier			29c. Licanse	number	11/1	29d. Dete signe	d (Month, Day, Yea	ir)	
	Jui chil	Han Ms		000	4823		8/10	12000		
	30. Name and address of person who	Completed cause of deeth (Ittel 4SU MD 2	em 23a) (Type, Print)	1 1	T 11-	-1-	10/210		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Margaret Juanita Hood 6 2000 August 3:10 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Lions Manor Nursing Home Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Apr. 2 193 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Days Hours 69 217-28-9887 Yrs 1931 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

10f. Zin Code

owner-editor

26750

1 ☐ Yes 2ENo Specify:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Funeral Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director Funeral þ Completed Hygiene.

filed within 72 hours after iges 1 and 2 should be filed at of Heelth and Mental Hygid if frem 27 is marked other Peges 1 and 2 should permit. Pege Department of Important: If any injury or once.

Baitimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Physician /Medical Examiner

and physician the 980 0 detached signed b certificata director. Certification: To this

or Attending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. edical

Be disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical þ Completed Be

WV Mineral Piedmont 10e. Street and Number 33 East Fairview St. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give 1 Never Married 2 Married 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Lester Hendley 19e. Informant's Name/Relationship (Type, Print) William Hood/ husband 20a. Method ol Disposition 1 ☐ Burlal 2 I Cremation 3 ☐ Removal from Stete 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee Immediate Cause (Finat

Juanita Hendley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 East Fairview St., Piedmont, WV. 26750 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete competery, cremetory or other place)
Cumberland Crematory 08/07/00 Cumberland Md. 22. Name and Address of Fecility Boal Funeral Home 111 Church St., Westernport, Md. 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervet Between Onset and Death

18. Mother's Neme (First, Middle, Meiden Sumeme)

Due to (or as a consequence of): ronau Due to (or as a co Due to (or as a consequence of):

Pert tt. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 200 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 XNatural 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of cedilier

29c. License number

29d. Date signed (Month, Day, Year)

1 Yes 2 □ No

10o. Citizen of What Country?

United States

16b. Kind of Business/Industry

newspaper

14. Race - American Indian Black, White, etc.

Specify: White

eleted cause of death (from 23a) (Type, Print)

Old town Road imala Kan 31. Date tiled (Month, Day, Year)

Registrar

5

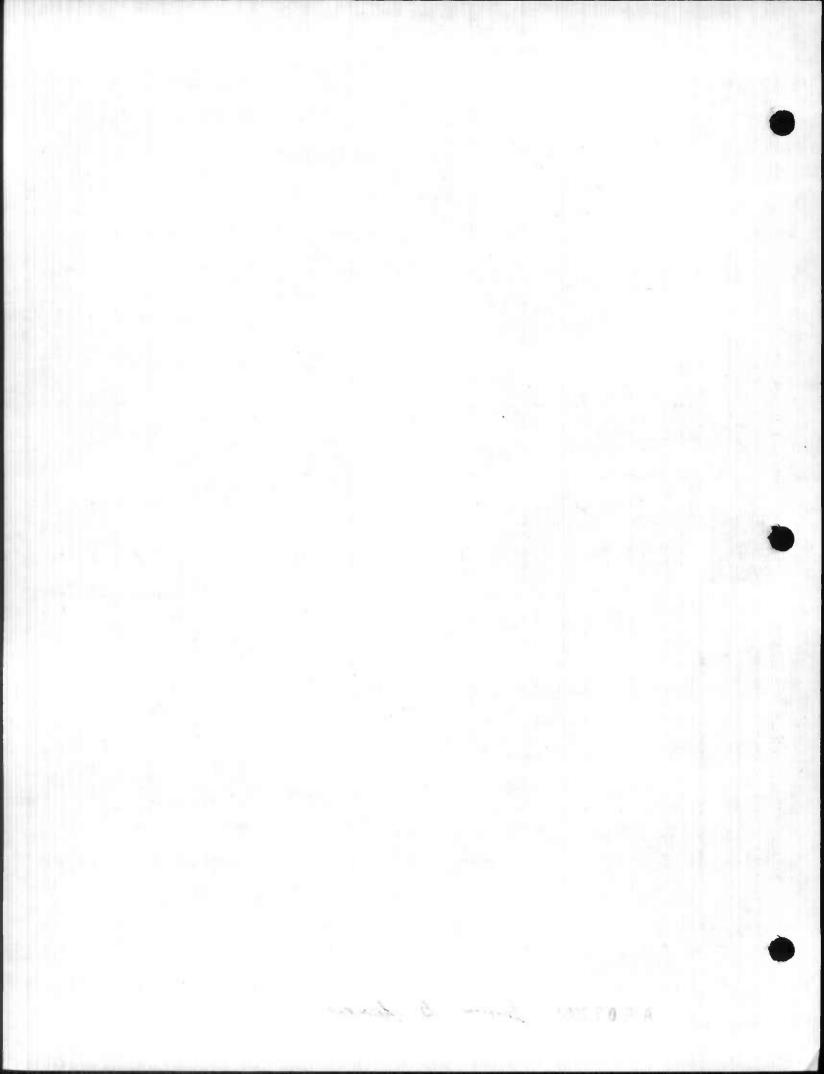
My

29a. Certifier

(Check only

AUG 0 7 2000

32. Registrar's Signature



Arrendett 196, mla, 812/00 Allegany Co

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Department of Health and Mental Hygiene	
Cartificate of Doath	0

	1. Decedent's Nam	ne (First, Middle	Lest)		08	lillica	le UI	Death		2. Date of Dea	Reg. No.		3. Time of Death
an al	WILMA	DAMN		SLER						Month AUGUST	Day		
er	4a Facility Neme (give street and nur	nber)				4b. City, Tov	wn, or Lo	cation of Death	4c. County	of Death	
	503 BEI		TREET			7 - 11 1 - 2		CUME				LEGAN	
	5. Social Security I	5229	Sex 1 M 2 F	7. Age (In yrs 77	. last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day MAY 18	h, Year) 1923	9. Birthplac Country MARYL	a (State or Foreign) AND
- 1	Usual Residence o 10a. State	10b. County		10c. C	ity, Town or Lo	ocation						10d.	. Inside City Limits
ğ	MD	ALLE	GANY	C	UMBER	LAND							1 Yes 2 □ No
Director	10e. Street and Nu	mber					ip Code				10g. Citizen of	?	
	503 BEI	DFORD S	TREET			2	2150	2			U.S	.A.	
by Funeral		ied 2 Marrie	If Yes, Giv	rces? 2 No		Was Deci		dispanic Orig an, Mexican Specify:	gin? (Spe , Puerto	ecity Yes or No- Rican, etc.)	14. Rad Bla	ce - American ck, White, etc	
	3 Widowed		Year or Da	ites:	10+ D		21			16b. Kind of Busin			
Completed			grade completed)		16a. Dece (Give life.	kind of w	ork done use retire	pation during most d)	of worki	ng			
E	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)	SIT					DULIMITA			
00	17. Father's Name	(First, Middle, La	st)					18. Mothe	r's Name	SOCIAL SERVICI			
0	WILLIAM	M DAMM						ЕТ	HEL	BRANT	r		
1	19a. Informant's N	ame/Reletionship	(Type, Print)		19b. Maiti	ng Addres	ss (Street		al Route Number, City or Town, State, Zip Code)			ode)	
	LUCINDA	CUNNING	HAM / DAU	GHTER	505	BEDF	ORD S	STREET	, CU	MBERLAN	ND, MD	2102	21502
permit. Pages 1 a Department of He important: if her any injury or oths ands.	LUCINDA CUNNINGHAM / DAUGHTER 505 BEDFORD STREET, CUMBERLAND, MD 24- Da. Method of Disposition 1											14, 10, 10	
	21. Signature of Fi	A A	Lanker	aused the dee		UPCH	JRCH		AL H	IOME, P. IBERLANI or respiretory ar		i In	pproximete iterval Between inset end Death
	Immediete Cause disease or condition resulting in death)	(Final	a	Endometrial concurrent									3 years.
			b		or es e conse							1	0
TO THE PARTIES OF THE	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	enditions, namediate entying injury	c		or as a conse								
8	resulting in death)		d	Due to (or as a consec	quence of)	:						
Your	Part If. Other signif				sulting in the u	ınderlying	cause gi	ven in Pert f.	lg i		-4		ne cause of death?
The law requires that the deeth certicate has been signed by the attending page 2 should be detached for use Completed by Physician/M		arten	iscler	sia							Y98 2 No	3 Probet	
							-			24a. Was perfo	an autopsy med?	evaila	autopsy findings able prior to detion of cause ath?
5							W.			101	es 2 No	1 🗆 Y	res 2□ No
_	25. Was case referexaminer?	red to medical	Hospitel:				100		of Deeth	(Check only o	ne)		
2	1 Yes 2		101		ER/Outpatie			4 140			dence 6 □Ott		
tlon	7. Manner of Deat	5 Pending investigat	10,000	h, Day Year)	28b. Time o Injury	м	28c. Injui	ryat rk? ∣Yes 2⊟h		zaa. Describe i	now injury occur	Den	
Certification:	2 Accident 3 Suicide 4 Homicide	6 Could no determine	be 28e. Place	of Injury - At h g, etc. (Speci	nome, farm, st ify)					28f. Location (S City or Tow	Street and Numi yn, State)	ber or Rural R	Route Number,
	29a. Certifier (Check only	10 Certifying	Physician: To the	best of my kno	owledge, deat	h occurred	d at the time	me, date end	f place, a	and due to the d	cause(s) and m	anner as state	ed.

To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by

DHMH 16 Rev 6/95

Tus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Breza, M.D.

- 912 Seton Drive, Cumberland, MD 32. Registrar's Signature

State

29b. Signature and title of certifier

29c. License number

2532

21502

29d. Date signed (Month, Day, Year)

200

Endometrial Communica

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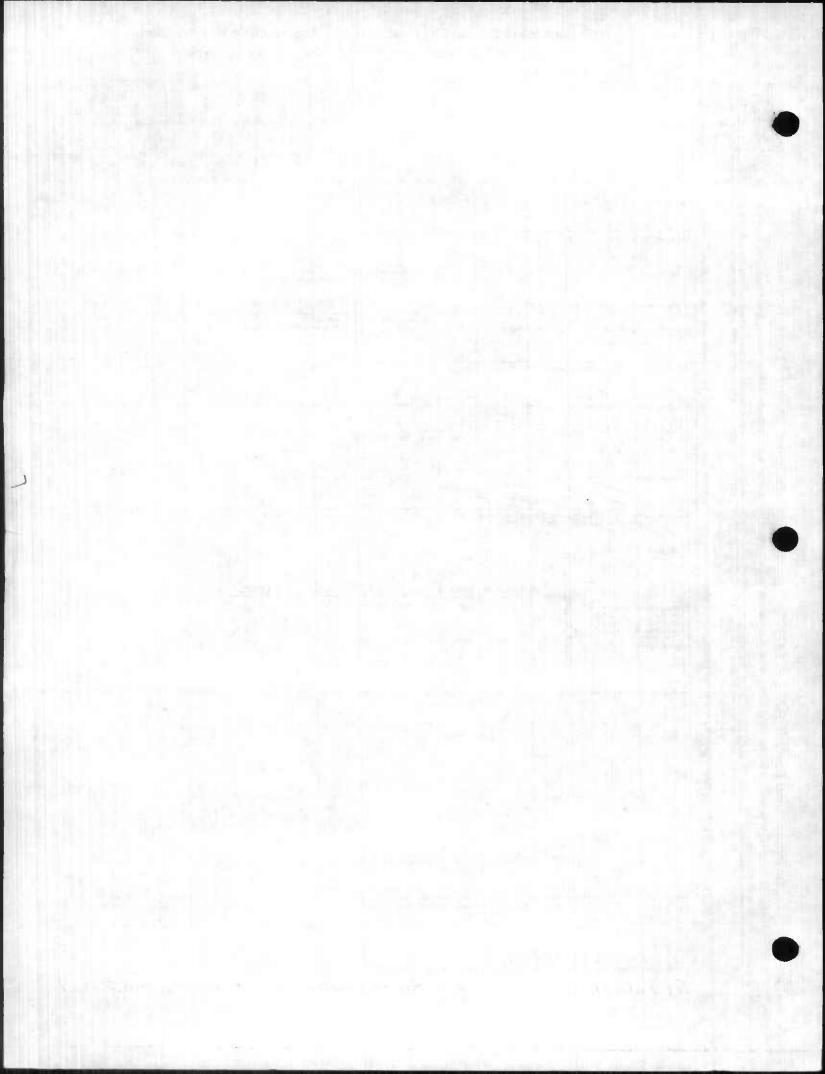
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State of Maryland / Department of Health and Mental Hygiene

					Certif	icate of i	Death		Reg. No.			
	Physician /Medical	Decedent's Name (First, Middle	(a, Last) Charles W	illiam Huf		2. Date of De Month	Dey	Year 3. Time of Death 9:40 AM				
	Examiner	4e Facility Name (If not institution	n, give street and numb	ber)		4	lb. City, Town, o	or Location of Deat		of Death		
		Sa	acred Heart I	Iospital				berland				
ı	Funeral Director	5. Social Security Number 214-07-3365	6. Sex 7 12≾ M 2□ F	. Aga (In yrs. last b	"I'll tody	Under 1 Year lonths Deys	If Under 24 H Hours Mi	n. (Month, Di	y 19, 1919	9. Birthplace (Stata or Foreign West Virginia		
	D .	Usual Rasidence of Decedent 10a. State 10b. County		10c. City, Toy	um or Locatio	00				10d. Inside City Limits		
	vith the Maryla t or 28a-f short be notified at Director	Maryland	Allegany	100. Ony, 100		(Cumberla	nd		1 Yes 2 No		
	23a or 2	10e. Street and Number 529 Ct	umberland St			10f. Zip Code	21502		10g. Citizen of W	USA		
020	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, for Medical Earth for must be notified at traumatic event, for Medical Earth for must be notified at To Be Completed by Funeral Director	11. Meritat Statua 1 Never Merried 2 Mer 3 Widowed 4 Divorced	If Yes, Give			S Decedent of Hes, specify Cube	ispanic Origin? on, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Specify:	e - American Indien, k, White, etc.		
0	2 ho		nt's Education	168	a. Decedant	's Usuel Occup	etion		16b. Kind of Bu	siness/Industry		
21215-0020	ed within 72 ho ygiene. or then "neture t, the Medical Completed	(Specify only higher Elementery/Secondary (0-12)	college (1-4	for 5+)	(Giva kind lifa. DO	-	during most of w f) rpenter	vorking	Construction			
Maryland 2	should be filed within and Mental Hygiene. marked other than amadic event, the Marian To Be Comp	17. Father's Name (First, Middla,	rles William	Huff, Sr.			18. Mother's N	a) ice)				
IN	and Menial same marked	19e. Informant's Neme/Ratations			b. Mailing A	ddrass (Street	and Number or	Rural Routa Numb				
	if Health and 2 s if Health an item 27 is other trau	Dale	L. Huff /Sc	on	2	25600 Ro		Farm Ln.,	Flintstone,	MD 21530		
Baltimore,	Pages nent of ant: If it	20e. Method of Disposition 1 Burial 2 Cremetion 4 Donation 5 Other (S		cemata	ary, cramato	on (Nama of ory or other place morial P		8/14/00	Cun	City or Town, Stete mberland, MD		
Ball	permit. Pag Department Important: I any Injury o	21. Signature of Fundamental Source	Liconson		22. Na	309-3			Funeral H mberland,	Iome MD 21502		
	Dharista	23a. Pert1. Enter the diseese, or shock, or heart failure. List	r complications that can t only one cause on each	used the deeth. Do ch line.	not enter th	he mode of dylr	ig, such es card	iec or respiretory e	errest,	Approximate the there are the the there are the the there are the the there are the th		
۱	Physician //wegical Examiner	Immediate Cause (Final diseasa or condition resulting in death)	faut	e Cere	brove	anula	fore	dent		5days		
	<u> </u>	resouring in county		Due to (or es a	a consequer	nce of):						
30,	e executed slan and unal-transit	Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	consequen	nce of):						
ox 68760,	eeth certificate be executed attending physician and I for use as the buriet-transit clar/Medical Examir	thet initieted events resulting in death) Last	d	Due to (or es a	consequen	nce of):						
B	death e atter ed for u					4 to 2 to 2		anh Did		at the day to the same of death 9		
P.O.	by the	Pert It. Other significant conditions Constst torre	14	Fauler	In the unda	nying cause giv	en in Per I.			atributa to the causa of death? 3 Probably 4 Unknown		
Records,	s been sign 2 should be pleted by	Chimie	obstacl	time Pul.	more	ny oh'	seare	24a. We:	s an eutopsy ormed?	24b. Wera eutopsy findings evallable prior to completion of cause of death?		
æ	The law ate has page 2							10	Yes 20 No	1 ☐ Yes 2 ☐ No		
Vital	certificate rector, pag	25. Was case referred to medica	ıl				26. Pleca of D	Death (Check only	ona)			
>		examiner?	Hospitel:	patient 2 ER/C	Outpatient	3 DOA OIT	er: 4 Nursing	Home 5□Res	idence 6 Othe	er (Specify)		
on of	B je co	27. Manner of Death 1. Naturat 5 Pendir 2 Accident investi	28a. Deta of (Month,		. Time of Injury	28c. tnjur Wor M 1	y at k? Yes 2 □ No	26d. Dascribe	how injury occurr	ed		
Division	To the Hospital or Attending Physical to the Funeral Director: After this completely filled in by the funeral of Medical Certification: To Medical Certification: To	3 Suicide 6 Could 4 Homicide detam	not be 28e. Piece o	of Injury - At home, I g, atc. (Specify)	ferm, street,	, factory, office		28f. Location City or To	(Straat and Numb own, Stata)	er or Rural Routa Number,		
	To the Hospital or within 24 hours after To the Funeral Dirth completely filled in Completely filled in Medical Cert	29a. Certifier (Check only 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manna (Check only 20a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manna (Check only) 20a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manna (Check only) 20a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manna (Check only) 20a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manna (Check only) 20a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manna (Check only)										
	To the To the Somp	29b. Signature and title of certifie	r			29c. Licans	a number		29d. Date signed	d (Month, Day, Year)		
	2	1							AUGUST	10, 2000		
	245	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) DR SUNIL GUPTA - 625 KENT AVE, CUMBERIAND, MD Q1500										
	State	31. Date filed (Month, Day, Year)		gistrer's Signetur	de	outs						

State of Maryland / Department of Health and Mental Hygiene 00 26551

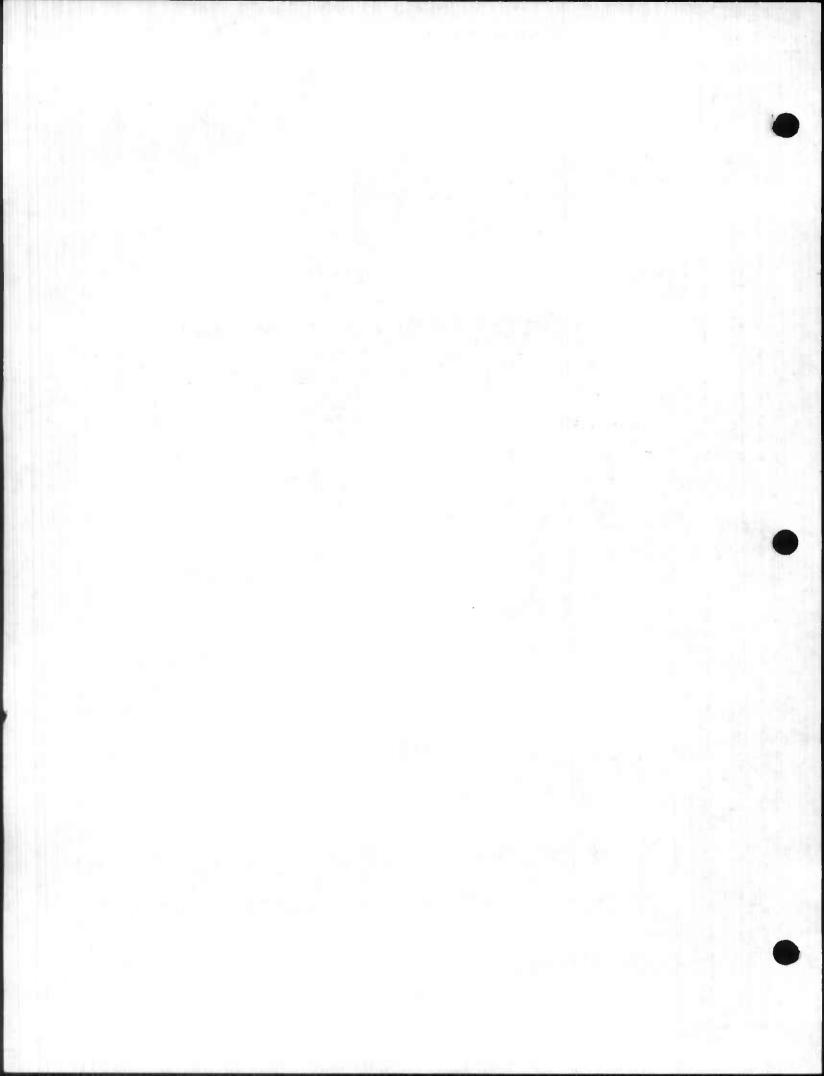
							Ce	rtifica	te of	Death			Reg. No.			
			1. Decedeni's Name (First, Middle,	Last)								2. Dete of De			3. Time of Death	
-	Physicia	n	Katherine C		Tohnaon							Month	Day	Yeer	0240	
	/Medica	_	4a Facility Name (If not institution,							4b City To	wn orle	July cation of Death	30,	2000 nty of Death	0240	
	Examine	er		-						40. Ony, 10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,000.011 01 2000.0				
			The Memorial	Ho	spita.	L					ston			lbot		
	Funeral		5. Social Security Number	6. Sex		. Age (In yrs.	last birthday)		or 1 Year		24 Hrs. Min.	8. Dete of Birl (Month, Da	h v. Year)	9. Birthr	place (State or Foreign	
	Director		212-32-4825	11_) M 2∯F	87	Yrs.	IVIOTAL 1	Dayo	110010		June 15			Virginia	
	70		Usual Residence of Decedent							-			,			
	of the		10e. Slele 10b. County			10c. Cr	ty, Town or Lo	ocalion						1	10d. Insida City Limits	
	A PER	ò	Manual - 1 0	A											1 ☐ Yes 2 XNo	
	2 40	Directo	Maryland Queen 10e. Street and Number	n A	nnes	Q1	ieensto		ip Code				10g. Citizen o	of What Cour	ntn/?	
			Toe. Street and Number					101. 2	ip Code			Tog. Onizon of What Country				
	€ 8 H	ē	149 Scott To	own	Road				1658							
1	E B	9	11. Marital Stetus		 Was Deced Armed Ford 		I,S. 13.	Was Dec	edent of ecify Cut	Hispanic Ori	lgin? (Sp	ecify Yes or No Rican, atc.)	- 14. F	Race - Americ Black, White,		
0	a de	2	1 Never Merried 2 Marrie	ed	1 Yea 2	⊠ No		1□ Yea				Specify:				
02	1 1	à	3₺ Widowed 4 □ Divorced		If Yes, Give Year or Dat	ea:		ILL TOB	240J NO	эреспу.			Spe		lack	
9	S ho	Pe	15. Decedent's	a Edu	cation		16a. Dece	dent's Ua	uel Occupation 16b. Kind of Business/Industry						dustry	
215-0020	in the state of th	9	(Specify only highest	grade			(Give	kind of w	ork done use retire	during mos	it of work	ing				
212	the section	Comple	Elamentary/Secondary (0-12)		College (1-4	for 5+)						2013	Come	1		
	The Party of	ပို	12 17. Father's Neme (First, Middle, L	o net			Home	Make	r	10 Moth	or's Nome	o /Eiret Middle			se's home	
land	to de la	m	17. Father's Neme (First, Middle, L	MSI)						18. Mothar's Neme (First, Middle, Maidan Surname)						
Sal	Men Wen	0	Unknown							Lo	ttie	Walk	er			
Mary	to E		19a. Informent's Name/Ralationsh	wn, State, Zip	Code)											
William Co.	2000		Charles E. John	ารถ	n/Broth	in er/law	149 9	cott	Tow	m Rd	011	eenetou	n Mary	land 2	1658	
9	Tag Had	Charles E. Johnson/Brother/law 149 Scott Town Rd., Queenstown, Mary 1 20a. Method of Disposition (Same of Company) 20b. Place of Disposition (Same of Company) 20c. Location											on · City or To	own, State		
more,	0 = 0		1 Buriel 2 Cremetion 3 Removel from State 4 Donalion 5 Other (Specify) camatery, crematory or other place) Capitol Crematory 8/3/2000 Dover, Description of the place of the													
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a	E S S S S S S S S S S S S S S S S S S S	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility														
	88158		Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601													
		+	23a. Part 1. Enter the disease, or o	empli	cetions that car	used the dea	th. Do not en	tar tha mo	da of dy	ing, such as	cardiac	or raspiratory a	rast,	Approximata		
	35-24		shock, or heart failure. List of	only on	ne cause on ear	ch line.									Interval Batween Onset and Death	
	Physician (Madical													1	. /	
	/Medical Examiner		Immediate Cause (Final disease or condition			Kes	P.CC	eto	(-/	FC	1. 10	se			10a-1	
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	be executed sician and bunal-transit	Ē	Conventially list conditions	P 6). ———	Due to (or as e conse	nuance of	1.	0.0		-				
-	exact n an an all aftr	X	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying		51-1001 11 121										3dc/s	
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87	phys the	용	resulting in death) Last			Due to (d	or as e consec	quence of):							
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Boy	attending for use a				J										Total and the same	
	death e atte	Physician	Part II. Other significant condition	18 con	Iributing to dea	th but not res	sulting in the u	inderlying	cause g	iven in Pert	1.	23b. Dld	tobacco use	contribute t	to the cause of death?	
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Records,	requires that the death certificata be execu- seen signed by the attending physician and should be detached for use as the bunal-tra	a DV										24a Was	en autopsy	24b. W	/ara autopsy findings	
9	been si should	Completed										perfo	med?	81	vailable prior to	
ec	2 S S	٥	E. Jewish at the				40.00							of	ompletion of cause death?	
Œ	certificate has t	0										10	Yes 2 No	0 1	☐ Yes 2☐ No	
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of	8 3 1	-	1 ☐ Yes 20 No 27. Manner of Death				28b. Time of		202	4014	ursing Ho	ome 5 ☐ Resi 28d. Describe			my)	
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0	Attending or death.	N N	2 Accident Investig					М	1[Yes 2	INO					
Division	after de Directe	Ĕ	3 Suicide 6 Could no datarmir	ot be ned	28a. Placa o	of Injury - At h	ome, farm, st	reet, facto	ry, office			28f. Location (City or To		imber or Rur	ral Route Number,	
Ö	after after din by	Certification:	/		Danaitig	, a.o. (opeci	-//					2, 0 0	,			
	Hospital 24 hours a Funeral stely filled		29a. Certifier 12 Certifying	Phys	fclan: To the b	ast of my kno	owledga, daet	h occurre	d at tha t	lima, date ar	nd place.	and dua to tha	cause(s) and	manner as	stated.	
		edical	29a. Certifier 12 Certifying Physician: To the bast of my knowledge, daeth occurred at the time, date and place, (Check only (Check only one) 13 Certifying Physician: To the bast of my knowledge, daeth occurred at the time, date and place, (Check only one)													
	within To the comple												29d. Date sig	aned (Month	Day, Year)	
	P N N		20. Signeture and title of carries E 3aber Nega MD BN42446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E i 2abeth Nega MD 2/9 South Washing Ton, 31. Date filed (Month, Day, Year) 32. Registrar's Signature								0.					
			7 9 .3	ab	ole 1	ega	MO	1	3 N	421	140	09	Of-	30-	00	
			30. Name and address of person w	vho co	mpleted cause	of death (Ite	m 23a) (Type,	Print)		401						
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ledical aminer	4a	Facility Name (II	not institution, giv	e street and number)			4b. City, T	own, or Loc	alion of Death	_			
		CIVISTA MEDICAL CENTER					M.Hadaa 4 Va	LAPLATA CHARLES (eer frunder 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Birth (Month, Day, Year) 67 Philip						
eral ctor		Social Security N 565-97- uat Residence of	8485	M 2DF	ge (In yrs. k	est birthday) Yrs.	Months Da		Min. Sept	8. Date of Birt (Month, Day ember	15,19	9. Birthp Coun	place (State or Foreign (17) hilippin	e
or 0	-	a. Stete MD	10b. County Charle:	S		Town or Loc							0d. Inside City Limits	- 1
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To Be			E. Jos					F	e Gom	nez				
	19	a. Informant's Na	me/Relationship (Type, Print)	CH P	19b. Mailing	g Address (Str	eet end Num	ber or Rural	Route Number	er, City or Town	Stete, Zip	Code)	2
	-		ez/Moth	er	Tack Di				r. Ap				sa,CA 926	- 2
5	200	a. Method of Disp	Cremation 3	Removai from State	9 1		sition (Name or latory or other		7717 C	Date /12/0	20c. Location		ce Hall,	AT)
and color		. Signature of Fu	5 ☐ Other (Specifineral Service Licer	nsee MC	0945	22.	1d-Ecl	dress of Fac	ility					
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in by me funeral director, page 2 should be detached for use as the bunal-transit of page 2 should be detached by Physician/Medical Examiner	See it a caa caa caa caa caa caa caa caa caa	mediate Cause (sease or condition sulting in death) equentially list control in the cause (please or candition to the cause (please or candition) the cause (please or candition) the cause (please or candition) the cause of cause or candition in the cause of cause	Final nditions, mediate rying injury .ast	b	Due to (or	TIC II as a consequence as a consequenc	wence of): uence of):	26. Pla Other: 4 1	7 IA s cardiac or N t t. ce of Death Nursing Hom 2	23b. Did 1 1 24e. Wes perfo	tobacco use co Yes 2 No en eutopsy rmed? Yes 2 No one) dence 6 Ott how injury occu OWN Street end Num vn, State) 11	ontribute to 3 Pro	Approximate Interval Between Onset end Death Onset end Death of the cause of death bebly 4 Unknown dere eutopsy findings vallable prior to impletion of cause death? Yes 2 No	
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State Registrar AUG 1 4 2000 Deneva



State of Maryland / Department of Health and Mental Hygiene 25553

			Certificate d	of Death	R	eg. No.	20000			
	1. Decedent's Name (First, Middle, Last	0			2. Date of Dea	th	3. Time of Death			
Physician /Medical	John Samue	1 Keeney Sr.			Month 08	Day Year				
Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	4c. County of De	ath			
	21611 Keeney F	Road		Freela	and	more				
Funeral Director	5. Social Security Number 6. Se 183–18–5591	7. Age (In yrs. Ia M 2□ F 79	Yrs. If Under 1 Ye Months Da			Year) 9. Bi	rthplece (State or Foreign Country) PA			
2	Usual Residence of Decedent									
effer death with the Maryland or Nems 23s or 28s-f show minst must be notified at Funeral Director	10a. State 10b. County MD Baltir		Town or Location eeland			10d. Ínside City Limits 1 ☐ Yes 2 ☑ No				
vith the Ma s or 28a-1 s be notified Director	10e. Street and Number		10f. Zip Cod	le	1	0g. Citizen of What C	Country?			
3a o	21611 Keeney	Road	53		USA					
free death v		12. Was Decedent Ever in U,S	Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			14. Race - Am	14. Race - American Indian, Black, White, etc.			
72 hours after natural, or he	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No 194 If Yes, Give Year or Dates: 194	3- 1 Yes 201	H Yes, specify Cuban, Mexican, Puerto Ricar 1□ Yes 2★ No Specify:			White			
"natural",	15. Decedent's Edu	194	16a. Decedent's Usual Oc	Sa. Decedent's Usual Occupation			of Business/Industry			
c - 4	(Specify only highest grad	le completed)	(Give kind of work do life. DO NOT use re	ne during most of wo tired)	orking	Tool Name of December 1				
filed within Hygiene. ther then the fire then the fire th	Elementery/Secondary (0-12)	College (1-4or 5+)	Truck Dr	Truck Driver			ernment			
EIPE A	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Meiden Sumeme)				
2 should be and Mental a marked o aumatic av	Paul T. Keeney	7		Sarah	E. McW	illiams				
d 2 should be h and Mental 7 is marked of traumatic ave	19a. Informent's Name/Relationship (T)		19b. Mailing Address (Str				Zip Code)			
and 2 seeith ar 27 is her trau	Frances E. Kee	nev / Wife				land, MI				
- I I I	20a. Method of Disposition	20b. Pla	ace of Disposition (Name of			20c. Location - City o				
Page nent o int: if iry or	1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Mt.	Zion Cemet	tery	2000	Freelar	nd, MD			
pemit, Pa Departmen Important: any Injury anca.	21. Signature of Funeral Service Licent	irtenstein	22. Name and Ad J.J.] 24 Sec		ein Mor	tuary, I	nc. PA 17349			
Physician	23a. Party Enter the disease, or compleshook, or heart failure. List only of	ications that caused the death. ne ceuse on each line.	Do not enter the mode of	dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Metastalic	c Cancer	Unknow	659	6 weeks				
P #		Due to (or:	as a consequence of):			0	10 W/w.			
sweuted n and ial-transit Examine	Sequentially list conditions.	D	as a consequence of):							
EX EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Determores	Osteoporosis				2 48			
ficate be speculed physician and is the bunal-transit edical Examir	that initiated events resulting in death) Last	U. The state of th	Due to (or as e consequence of):				1			
E 00 5		. Supra Venticular Tachycardia					3 yes			
seath ce attendig of for use	Det II. Other elevidiens conditions con	stalle stime to almost but and and annual	OOD DIVI	23b. Did tobacco use contribute to the cause ol death						
d by th	Part II. Other aignificant conditions cor	ntributing to death but not resulting in the underlying cause given in Pert I.				1 Yes 2 40 3 Probably 4 Unknow				
stelen: The law requires the certificate has been signe rector, page 2 should be completed by					24a. Was a perform		. Were autopsy tindings available prior to completion of cause of death?			
The I					1 🗆 Y	es 200	1 ☐ Yes 2 ☐ No			
certificate rector, page Co	25. Was care referred to medical									
	examiner?	lospital:	R/OutpatienI 3□ DOA	Other: 4 Nursing I	/	ence 6 Other (Sp	ecify)			
a Physical dispersion of T. T.	27. Mann of Death	1		njury at Work?	7	ow injury occurred				
to a strength of the strength	2 Accident 5 Pending investigation 3 Suicide 6 Could not be	M 1 Ves 2 No 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28l. Location City or T				ocation (Street and Number or Rural Route Number, ity or Town, State)				
tal or A	4 Homicide determined									
To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by it Medical Certific	29e. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.									
within To the Comp	29b. Signature and title of certifier	Λ	29c. Lic	29c. License number			29d. Date signed (Month, Day, Year)			
	Riffert ma			044073			08-15-2000			
	30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Print) CONVEST AVE	Shrews	bury Pr	17361				
State	31. Date liled (Month, Day, Year)	32. Registrer's Signatu			0		•			

ME GEEN GOILS SL. EU and at your with a fit to the same of the fitter to I have

DHMH 16 Rev 6/95

State

Registrar

Stephen S: 31. Date filed (Month, Day, Year)

AUG 11 2000

Radentz

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** William Patrick Linn Aug 8, 2000 09:05pm /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 609 Hilltop Drive Cumberland Allegany ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days 10 M 20 F Yrs. Jul 26, Director 212-24-1535 71 1929 MD Usuet Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 1 Yas 2 No Directo 28a-f MD Allegany Cumberland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 609 Hilltop Drive 21502 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 □ Mes 2 □ No Korean
I Yes, Give
Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) "natural", or herra 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 M Married 21215-0020 1 Yas 2 No Specify: white Specify à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important; if Nem 27 is marked other the stry Injury or other traumeric design engineer engineering Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Homer H. Linn Norrine (Brislin) 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jeannine Linn 609 Hilltop Drive; Cumberland, MD21502 20a. Memod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Veterans Cem8/11/ Flintstone, MD 21. Signeture of Funeral Service Licenses Scarpelli Funeral Home P.A. Cumberland, Maryland enes 21502 h. Enter the disease, or complications that a great the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, k, or heart feilure. List only one cause on such line. Approximete Intervat Between Onset and Deeth **Physician** 15 /Medical Immediate Cause (Finet disease or condition resulting In death) Examiner Examine physician and the burial-transit certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Box 68760 Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): 80 signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were autopsy findings evailable prior to 24a. Wes an autopsy performed? completion of cause of death? 9580 1 Yes 2 No 1 ☐ Yes 2 No of Vital Be 25. Was case referred to medical funeral director 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Mostial or Attending Pi 124 hours after death.
 Funeral Director: After the idealy filled in by the funeral Division Neturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) alpe D54411 Aug 9, 2000 mon who completed cause of death (ttem 23a) (Type, Print) Beverly Mu Calkins M.D. 500 Memorial Ave Ste 105 Cumberland MD 2150 32. Registrar's Signety State Registrar

State of Maryland / Department of Health and Mental Hygiene 00 25556

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27 PER MEO G786 Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Pey 25 **Physician** 90 Rosie В. Mitchell 0104AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital Easton 5. Social Sacurity Number If Under 1 Yaar | if Undar 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours Min. Yrs. Director 215 36 0832 67 11 Md. Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Md. Talbot 1 Yes 2 No Director Easton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 119 Port Street 21601 U.S. Funeral death Hems ? 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ■ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican indian, Black, White, etc. 11. Maritai Status traumatic event, the Madical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 H No Specify: by Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Dacedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health end Mental Hygiene. em 27 le merked other than " Eiementary/Secondary (0-12) College (1-4or 5+) 10 Domestic Labor 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Be 2 William Mitchell Dorothy V. Mitchell 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Peges 1 and 2 nent of Health e int: If item 27 le 20b. Place of Disposition (Neme of cemetery, cremetory or other place) William Mitchell (son) Easton Md 21601 other 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 ■ Buriel 2 □ Cremation 3 □ Ramoval from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Richards Mem. Pk 7/28/00 Easton Md. 21. Signature of Funarai Service Licensee 22. Name and Address of Facility Dashiell Funeral Service 21601 322 East Ave. Easton Md. 23a. Part1. Entar the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical immediate Cause (Finel HYPERTENSIVE CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or as e consaquance of): Examine certificate be executed physician end the burial-tren Sequentially list conditions, if any, leeding to immadiate cause. Entar Underlying Cause (Disease or Injury that initiated avents resulting in deeth) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 80 use 0 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy parformed? Completed peeu hes page 2 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 12 Yes 2 No 1 inpatient 2 FR/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation deeth. 1 Yes 2 No ofter deeth Director: / J in by the f 2 Accident 6 Could not be 3 Suicida 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \(\text{Homicide} \) 24 hours e Funeral C Hospital 29e. Cartifier 1 🔲 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the causa(s) and mannar as statad. Medical 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) ş \$ within To the 29c. License numbe 29d. Date signed (Month, Dey, Year) 2

Assistant

Examper 111 tens St

State Registrar heodore M.

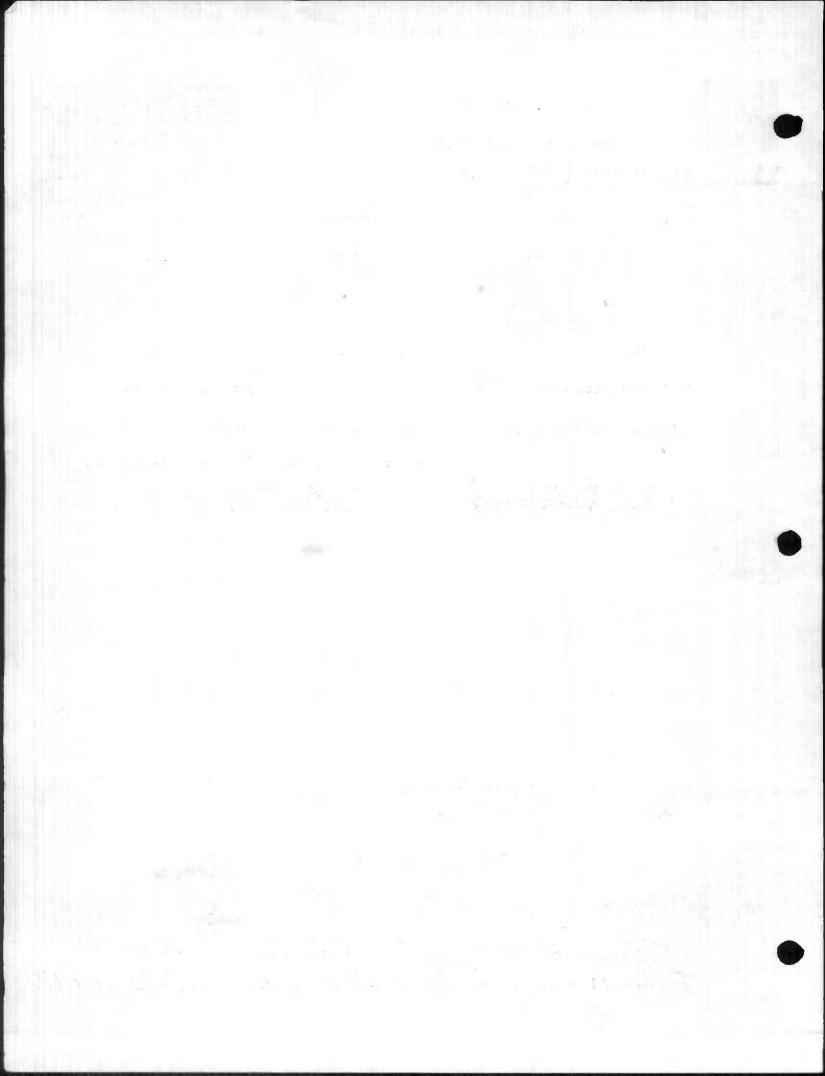
Mama and address of person who completed causa of death (Item 23e) (Type, Print)

32. Registpar's Signature

King

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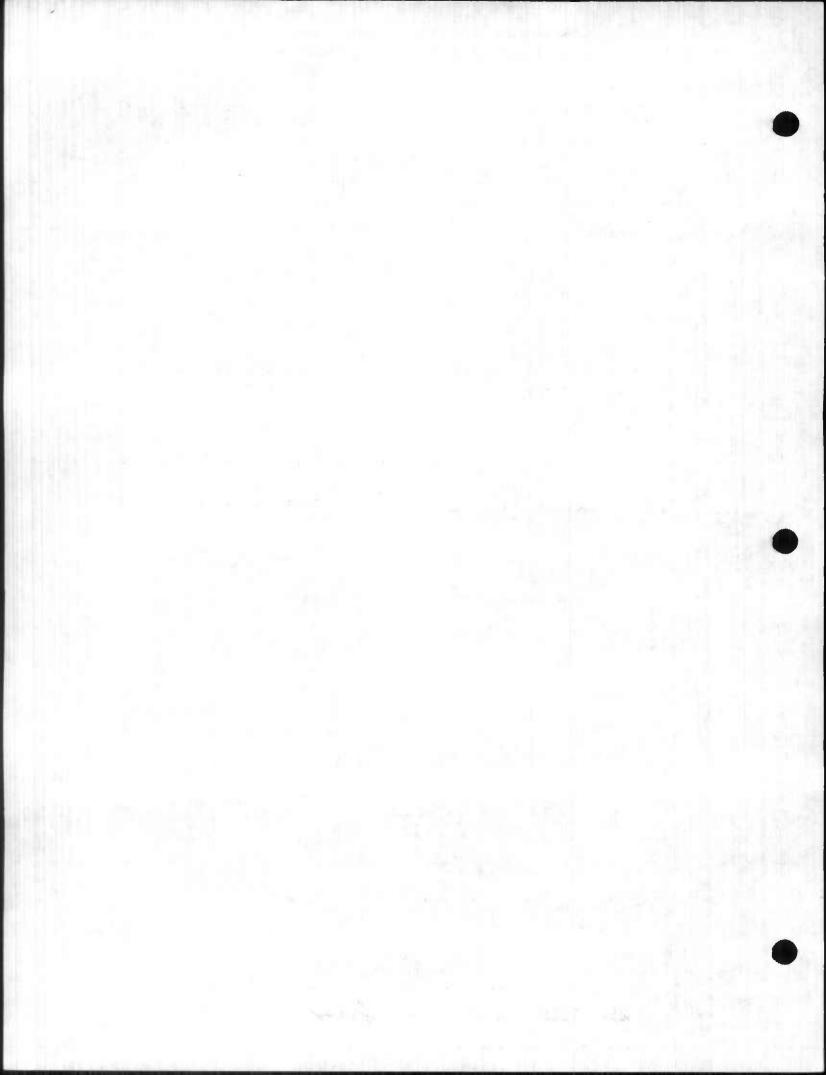


State of Maryland / Department of Health and Mental Hygiene

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/Medical	Joseph Eva								August	- /	MA	11:5	/
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Funeral Director	5. Social Security Number 218-09-9055	6. Sex 1 M 2 F		s. last birthday) Yrs.	If Under 1	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 21,	th y, Year) , 1913	9. Birthp Coun Mary	place (State or F ptry) Land	oreign
9	Usual Residence of Decedent				1								
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or 28s-f s	10e. Street and Number				10f. Zip (Code	1-1-1			10g. Citizen of	What Cour	itry?	-
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her des thems thems		Armed	ecedent Ever in Forces? s 2 X No		Was Decede It Yes, speci 1 ☐ Yes 2				ecify Yes or No Rican, etc.)	Specifi	ck, White,	etc.	
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emit. Pages 1 a lepartment of Hea mportant: If Item ny Injury or othe IDES.	1 Buriel 2 Cremetion 4 Donation 5 Other	(Specify)	m State	A. Ferr	matory or oti	her pla		8		West Ch			
Depart Depart Import Import In Import	21. Signature of Funeral Service	e Licensee	Liba	H:		Iome	for	Fune	rals, l	P.A. on, MD 2	1921		
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by the	Turn. Other algrimount contain	none contributing to	Godin Dol not re	DOUGHTY IN THE C	andonying ca	zuso y	von pri art			Yes 2 No			
signed by DI													
been si should							24a. Was peri	s an autopsy ormed?	av	ere autopsy tine ailable prior to ampletion of cau death?			
The law requires the law requires the last been significant because the last because the la									10	Yes 2 No	11	Yes 2 N	0
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tal or Attending P rs after death. al Director: After ted in by the funer Certification:	3 Suicide 6 Could 4 Homicide	d not be mined 28e. Pla	ica of Injury - At ilding, etc. (Spec	home, fam, st	reet, factory,	, office				(Street and Num wn, State)	ber or Run	al Route Numbe	97,
Hospi 14 hour Funer tely fill	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a end menner stated.									anner as s	itated. o the cause(s)		
within 2 To the comple	29b. Signature and title of certifier 29c. License number									29d. Date signe	ed (Month,	Day, Year)	
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Registrar



State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate of	Death		Reg. No.	
Physician	Decedent's Name (First, Middle, L.		0			2. Date of De Month	Day	Year 3. Time of Death
/Medical		Ann	Owens			Augus	1	000 09:20 A.M
Examiner	4a Facility Name (If not institution, g			70.0		or Location of Deat		
	Route 40 W/B			7 4/41 1 4 14	LaVal			legany
uneral irector	220-28-9375	Sex 7. Age	(In yrs. last birthday, 67 Yrs.	Months Days	Hours Mi		1933	Birthplace (State or Foreign County)
3	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. toside City Limits
al', or items 23a or 28a-f ahow Exercise cust be notified at by Funeral Director		gany		/ale				1 SYes 2 □ No
or 28e-f a be notified Director	10e. Street and Number	garry	Дач	10f. Zip Code			10g. Citizen of V	Vhat Country?
D P	12316 Henry Dr	ive S.W.		Tot. Zip Codo	21502		USA	via. Oodiniy
metic event, tre Medical Exerciser court To Be Completed by Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	dispanic Origin?	(Specify Yes or No)- 14. Rac	e - American Indian,
F. P.	1 Never Married 2 Married	Armed Forces?		Was Decedent of H It Yes, specify Cube	an, Mexicen, Pu	erto Rican, etc.)	Blac	k, White, etc.
by	3 Widowed 4 Divorced	It Yes, Give Year or Dates:		1 Yes 2 No	Specify:		Specify	white
Completed	15. Decedent's	Education	16a. Dece	edent's Usual Occup e kind of work done	pation	uncting.	16b. Kind of Bu	usiness/Industry
pie	(Specify only highest g	College (1-4or 5+	life.	DO NOT use retired	d)	rorking	0 3	Heart Hear
NO.	12		regis	stered n	urse		Sacred	Heart Hosp
Be	17. Father's Neme (First, Middle, Las	it)			18. Mother's N Kathry	lame (First, Middle	, Maiden Sumer Intire	10)
10	Joseph Webb				Raciiry	II K MC	Incirc	
	19a. Informant's Name/Relationship Cloyd O. Owens		19b. Meii 1 2 3 1 6	ing Address (Street Henry	and Number or Drive	Rural Route Numb	Vale M	State, Zip Code) D 21502
	husband 20a. Method of Disposition							
	20a. Method of Disposition Burial 2 Cremation 3	☐Removal trom State	20b. Place of Disp cemetery, cre	osition (Neme of emetory or other ple	ce)	Date	20c. Location -	City or Town, State
	4 Donation 5 Other (Spec	rify)	Rocky Ga	ap Veter	ans Ce	m8/07/		stone, MD
	21. Signature of Funeral Service Lic	ensee	ME	3carpe111	ni of Pune	ral Hom	ne, P.A	
	Michelan	1 May	0011:19	Cumberla	ind, MD	21502		
	23a. Part1. Enter the disease, or co shock, or heart tailure. List on	mplications that caused to	the death. Do not er	nter the mode of dyir	ng, such as cerd	lac or respiratory a	rrest,	Approximate Interval Between
n								Onset and Death
	Immediate Cause (Final disease or condition	Mui	tiple	injuri	ies			
	resulting in death)		Due to (or as a conse		19 717			
Examiner		t b						
Xar	Sequentially list conditions, if any, leading to immediate		ue to (or as a conse	equence ot):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C						
Physician/Medical	that initiated events resulting in death) Last	0	ue to (or as a conse	quence ot):				
n/Medical Examir		d						
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	27. Menner of Death	28a. Date of Injury	28b. Time	1		28d. Describe	how injury occur	red
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- La	- Tottliolde	building, efc.	tree +			0.11	1 Count	
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₹	29b. Signature and title of certifier	and manner stat		29c. Licens	se number		29d. Date signe	d (Month, Day, Year)
X	1/tala	1 4/1 1	N/T 1	1	O.C.M.E.		λιιο	niet 4 2000
0	30. Name and address of person wh	n completed cause of de	ath (lines 23e) (Tunn		V. C.PI.E.		Aug	rust 4, 2000
nlo		2a dent2		Penn Stre	et. Bal	timore	Marvland	21201
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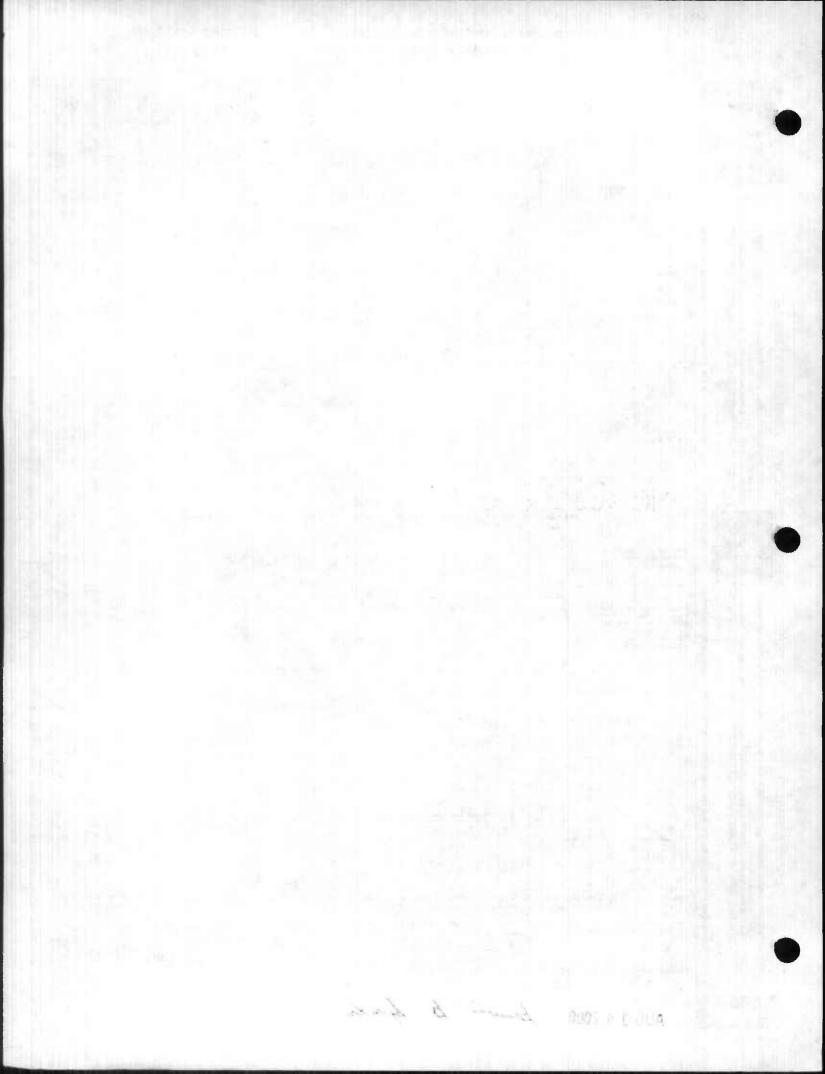
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ľ	Funeral Director		5. Social Security N 218-12-5		6. Sex	7. A	ge (In yrs. 76	iest birthdey) Yrs.	If Under 1 Year Months Days	Adams I Ada	8. Dete of Birth (Month, Dey, Mar 14,		9. Birth	place (State or Foreign
	E		Usuel Residence of 10a. State	Decedent 10b. County	,		10c. Cit	y, Town or Lo	cation					10d. inside City Limits
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020	sir, or flams Examiner m	by Funer	11. Meritei Ststus 1 Never Merri 3 Widowed		ried	Wes Deceden Armed Forces 1 Yes 2 ¹ If Yes, Give Yeer or Detes	? I No	1111	Wes Decedent of t Yes, specify Cub	Hispenic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		, White,	
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altimore	Pag mant if jury or		4 ☐ Burial 2 (4 ☐ Donation			nover from Stet				metery				lle, WV
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Division	pital or Attending Phone of Affector: Affect this line of the funeral	Certification:	3 Suicide	6 Could determ	not be	28e. Pieca of I	njury - At he	ome, term, str	reet, tectory, office		28f. Location (S City or Town	treet end Numbern, Stete)	er or Ru	ral Route Number,
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	To the How within 24 h	Me	29b. Signature and	etter of ourside	ar .	mal	10	4.)	29c. Licer	nse number	2	9d. Date signed	(Month	, Dsy, Year)
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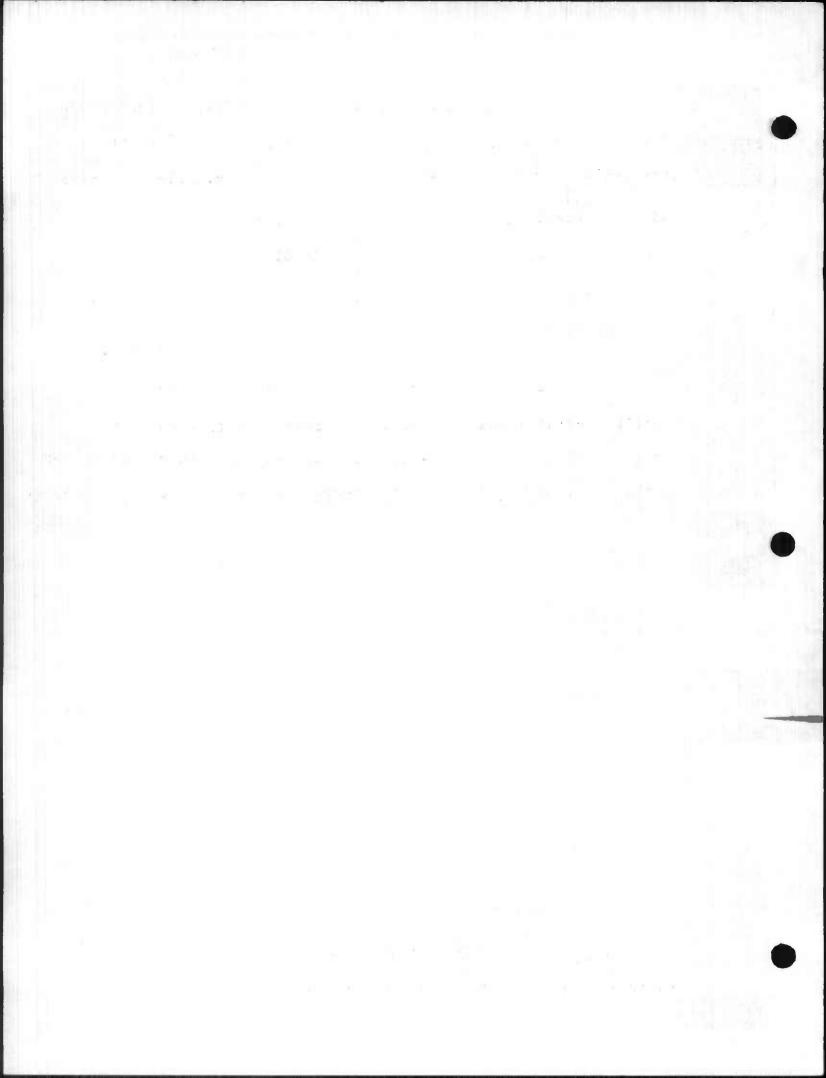
State of Maryland / Department of Health and Mental Hygiene 00 2656

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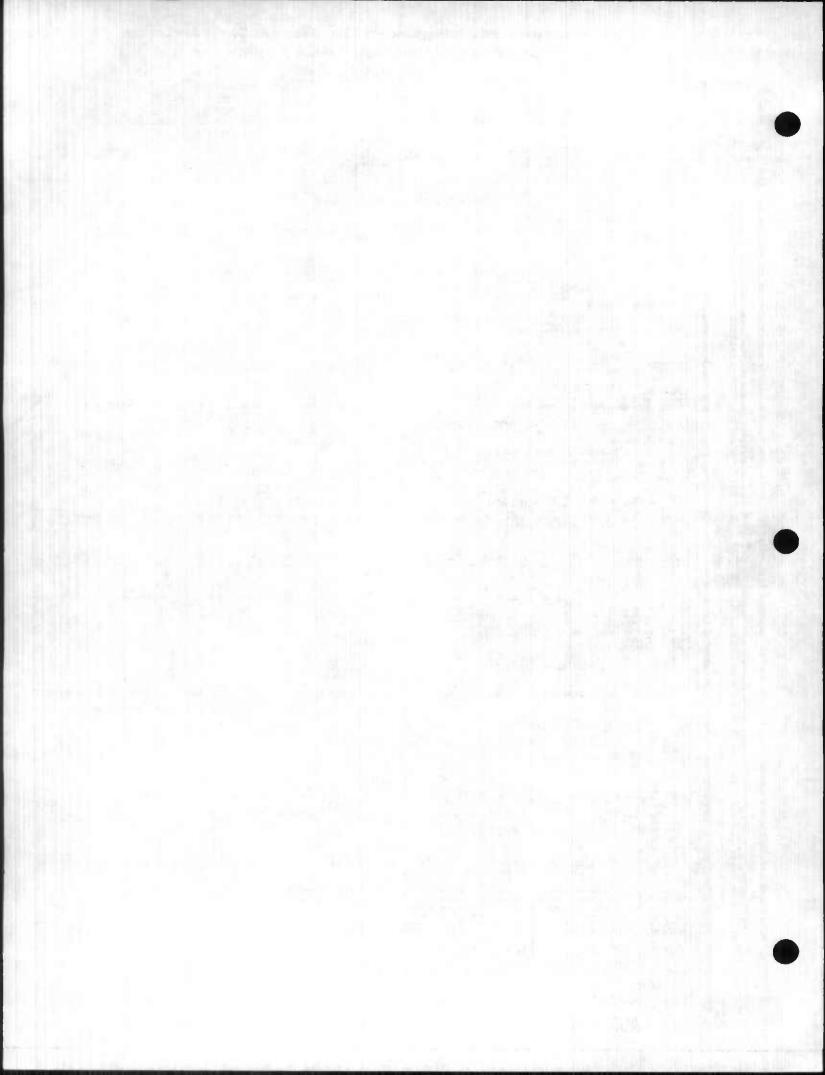
State of Maryland / Department of Health and Mental Hygiene

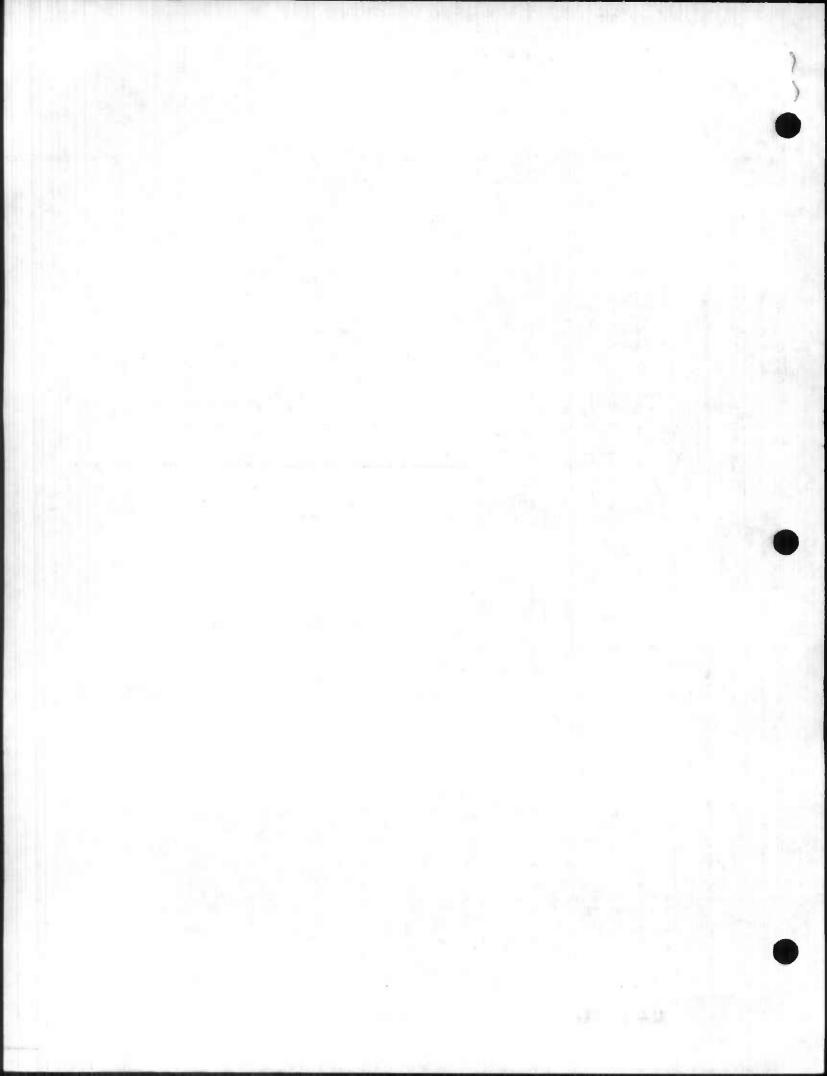
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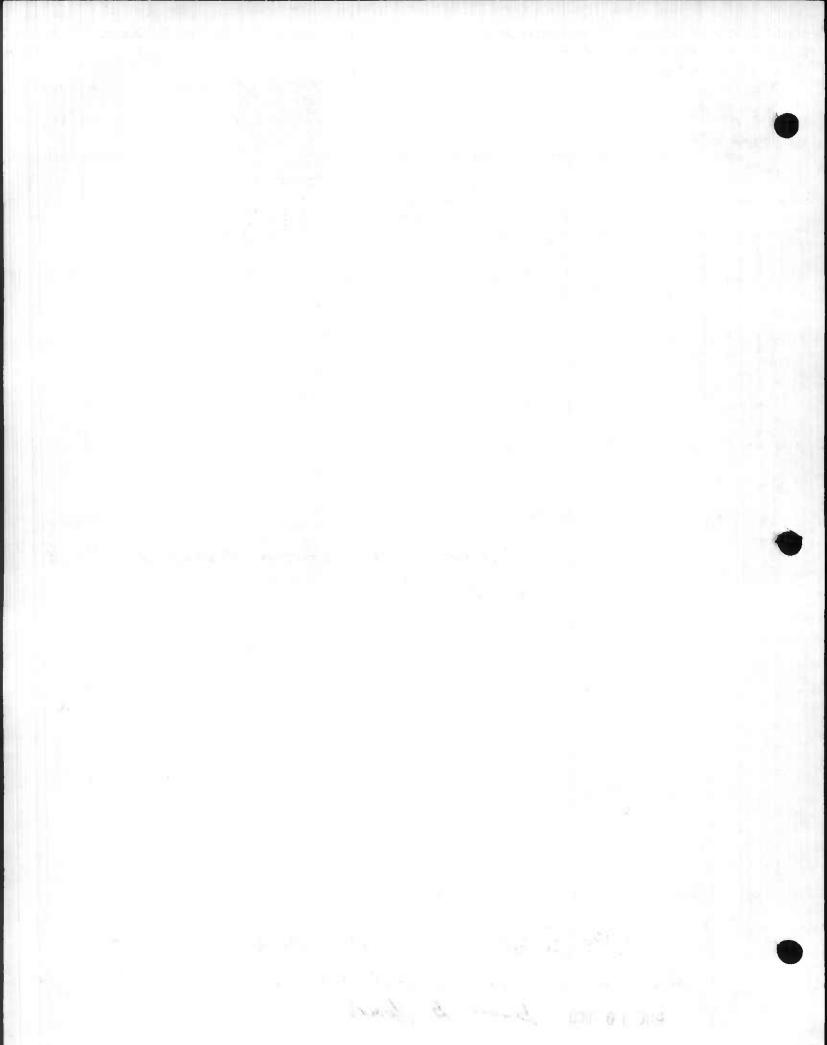


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physiclan** Aughth 6, 2000 Year 10:45am Stewart /Medical 4a. Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HCR Manor Care Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. Aug. Months, Pay. 1992 9 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2♥F 215-56-9152 71 Yrs. Director Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show items 23s or 28s-f shortner must be notified at Director 1K Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 N. Charles Street 21204 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Pages 1 and 2 should be liled within 72 hours efter neat of Health and Mertel Hygiene.
ant: if item 27 is marked other than "natural", or ite iny or other thaumate avent, its Musical Examine. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specifyhite þ Widowed 4 □ Divorced Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Retired Housekeeping Lions Manor NH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Jacob Kunkle Loretta V (Shaw) 19a. Informant's Name/Relationship (Type, Print) Virginia L. Deter 19b. Mailing Address (Street and Number or Rural Boute Number, Lity or Town, State, Zio Code) 314 Cecelia Street; Cumberland, MD21502 daughter 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Davis Memorial Cemeter8/09/ Cumberland, MD 21. Signature of Funeral Service Licensee Scarpe Weis of Funeral Home P.A. Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Frain disorder Immediate Cause (Final disease or condition resulting in death) **Examiner** Troke physician end s the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760 Physician/Medical Due to (or as a consequence of): attending i P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, ð should t Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? page 2 s certificate 1 Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: hin 24 hours after death. director Be 25. Was case referred to medical 26. Piace of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: / 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as ststed.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and tille of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0-12849 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 OSLER Dr. Towson Mel 21204 Mis 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar AUG 1 0 2000



						,		tifica				Mental H	Reg.	Ų	U	20.	301
Physician - /Medical	ı	1. Decedent's Nem		SNELSON								2. Date of I Month AUGUST		Day 2	Year 000		308
Examiner	4	a we will		HOSPITA						- 1	, Town, or MBERL	Location of De	ath		nty of Deat		
uneral frector	1	5. Social Security N 216 05 7		. Sex 1 □ M 2 🛣 F	7. Age 89		st birthday) Yrs.	If Unde Months	Days		nder 24 Hrs urs Min.		Birth Day, Ye	1911	9. Birti Co MAR	hplace (S untry) XYLAN	State or Foreign
fled at	-	Jsuat Residence o 10a. State MARYLAND	f Decedent 10b. County ALLEGA	NY			Town or Lo										ilde City Limits
at be notified at Director		10e. Street and Nu		REET				10f. Zij	Code 2	1532			10g.	Citizen o	f What Co	untry?	
Examiner must Examiner must by Funeral		1. Marital Status 1 Never Married 2 Married 1 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)						Was Dece f Yes, spe 1 Yes	ecify Cul	ban, Me	cican, Puer	specify Yes or to Rican, etc.)	No-	В	ace - Ame lack, White city: WHI	e, etc.	ian,
(Specify Elementery/Second		(Specify only highest grade completed) entery/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry					
other the rent, the last	17. Father's Name (First, Middle, Last		College (1-4or 5+)			FAC	CTORY	WOI				CELANESE CO			ORP.	DRP.	
To Be			st)								me (First, Midd		iden Sumi	ame)			
19a. Informant's Name/Relationship ALBERT SNELSON, 20a. Method of Disposition 1 Rurial 2 Cremation 3 4 Donetion 5 Other (Spec			PS01	.V						urel Route Nun				Zip Code,			
		20a. Method of Disposition 20th 1 Description 2 Descriptio					236 LAKE POINTE DRIVE, AKRON, OH 442 20b. Place of Disposition (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK 8/99/00 FROSTB							ate			
		· Alan	Mouse	5			60	W.	FUI MAII	NERA N ST	L HOM	E, P.A.	, M	ID 21	532		
· rsician	shock, or heart tallers, that ally one cause on each line.						60 W. MAIN ST., FROSTBURG, Mused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh line.					,		Interv	eximate val Between t end Deeth		
dical niner		Immediate Ceuse disease or condition resulting in daath)	òn	a. I3	her	nic	CA	-RD/	OM	yoj.	ath	4			_	17	monte
nsit niner				b. C0	RO	NA	Ry	AR	Tex	ey_	Des	cease			1	15	year.
cuted nd transit		Sequentially list co	anditions.			Due to (or a	as a consec	uenca of)	:	9							V

Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

arkonson

1 Yes 212 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

23b. Did tobacco use contributs to the cause of death?

25. Was case referred to medical examiner?

1 Yes 2 No

1 Inpatient 2 FR/Outpatient 3 DOA

28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No

28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14.R

th (Hem 23a) (Type, Print)

10701 New Learges Creek S. W Suite 3 Frostbury MD

Mlo State Registrar

signed by the ettending physician of the detached for use as the burial

cate has been sign. page 2 should b

certificate

After this

To the Hospital or much within 24 hours after death.

To the Funeral Director: Alt

funeral director,

Hospital or Attanding Physician:

Physician/Medical

þ

Completed

Be

Certification: To

Medical

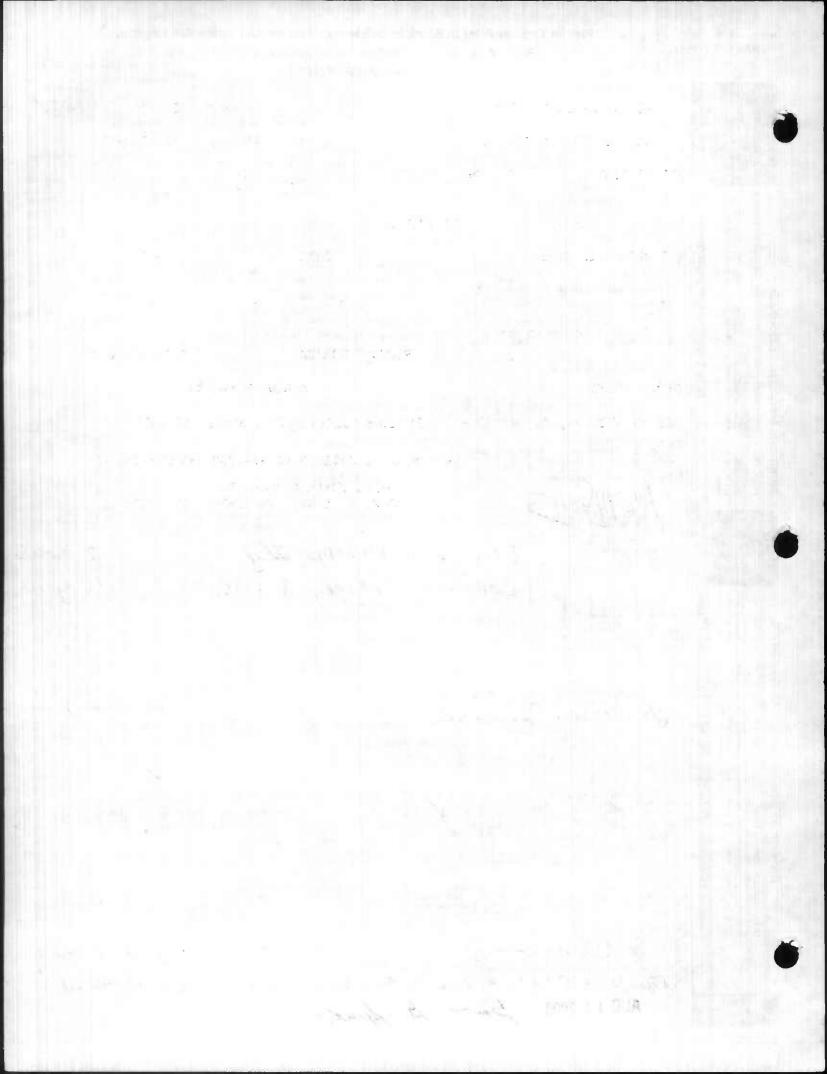
Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

DHMH 16 Rev 6/95

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

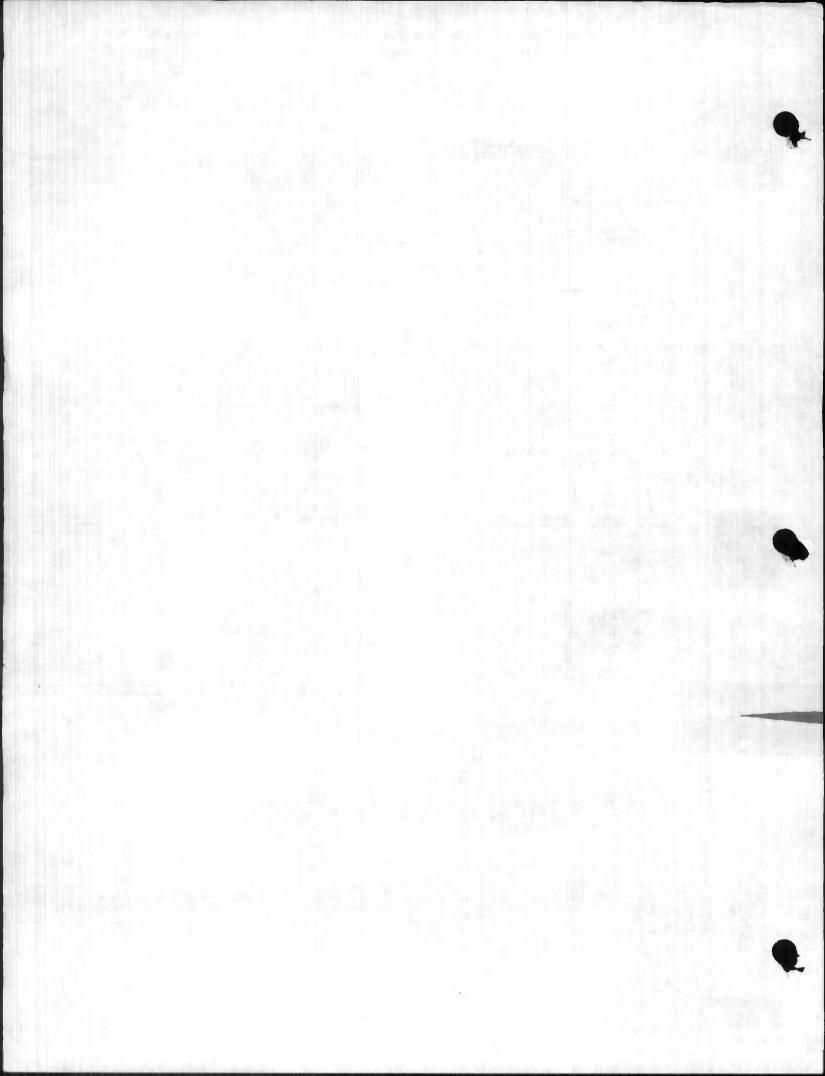


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
mend item 11 per fh G787 9/18/00 yf Certificate of Death

Reg. No.

amend item	11 per fh G787 9/18/00 yf	Certificate of Death	Reg. No.	20000
Physician	1. Decedent's Nama (First, Middle, Last) C. Hiering Sisco		2. Date of Deeth Month Day Yes	1 -0
/Medical	OUTTEET THE		Aug 3 20	00 6 P
Examiner	4e Facility Nama (If not institution, give street and number)	4b. City, Town, or I		
	University of Maryland Medica		ore Baltin	
Funeral Director	5. Social Security Number 6. Sex 7. Aga (In yrs. last 218 – 24 – 4303	r birthday) Yrs. If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	Birthplaca (Stata or For Country) Maryland
pu *	Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, T	Fown or Location		10d. tnsida City Lin
with the Marylar as or 28s-f show be notified at		Easton		1 ☐ Yas 2 🔀
23a or 2	10e. Street and Number 26709 Tunis Mills Road	101. Zip Coda 2 1 6 0 1	10g. Citizen of What United	
within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Maries Exercises must be notified at empleted by Funeral Director	11. Marital Status 1 Never Merried 1 Never Merried 2 Married 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yes 2 No H Yas, Giva Yaar or Detas:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Maxican, Puart 1 □ Yas 2 ☒ No Specify:	to Rican, atc.) Black, W	merican Indian, /hita, etc. B 1, à c k
72 h	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Giva kind of work dona during most of wor	16b. Kind of Busina	ss/Industry
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s marked of marked of aumatic av	19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Addrass (Straat and Number or Ru		
1 and 1 Health Im 27 I	Faye D. Sisco/Daughter 20a. Mathod of Disposition 20b. Place	26709 Tunis Mills of Disposition (Name of	Rd., Easton,	
10 F P	1 ဩ Burial 2 □ Cramation 3 □ Removel from Stata Rich		8/8/00 Easton	
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the death or diby the attend exacts of for us Physician/	Part II. Other significant conditions contributing to death but not resulting	ng in tha undarlying causa given in Part t.	23b. Did tobacco use contrib	oute to the cause of de
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The law mounts it page 2 should be Completed by			24a. Was an autopsy performed?	4b. Wara autopsy findia available prior to complation of caus of death?
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C pat	25. Was case rafarred to medical	20.5		1 L 169 Z L NO
sician certh rector	examiner?	Other	ath (Check only ona)	Canali I
Physics of the control of the To	27. Mannar of Death 28a, Data of Injury 28	VOutpatient 3LI DOA 4LI Nursing P	Homa 5 Rasidenca 6 Othar (\$ 28d. Dascribe how injury occurred	
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n 24 hours in 24 hours we Funeral It pleately filled edical Ce	29e. Certifiar (Check only one) Certifying Physician: To the best of my knowled (Check only one) Medical Examiner: On the basis of axambation and mannar steled	STVEE Code, death occurred at the time, deta and place a snd/or investigation, in my optnton, death occur	e, and due to the cause(s) end manna urred et the tima, date end place, and	ir as stated.
	29b. Signature and Jun of contribute	29c. Licansa number	29d. Data signed (M	fonth, Day Year)
THE S	Son Sylleting and Sylleting an	C A C LA	250. Data signed (M	27
	1000 save	7674	Angust	3,2000
	30. Name and eddrass of person who completed cause of death (Item 23 Melvin Stone 22 Sou	30) (Type, Print) the Greene Stre "G. Sparks"	et, Bultimore	Marylan
State Registrar	31. Data filed (Month, Day, Year) 32 Registrar's Signature	D. Sparks	(21



Stal 4a Facility Nar Union 5. Social Secur 241-26 Usual Residen 10a. State Marylar 10e. Street and 233 Fl. 11. Marital Stal 1 Never I 3 Widow (Elementery/) 6 17. Father's Na ROY St 19a. informent Valet 20e. Method of 1 \overline{\text{M}} Buriel 4 Donat 21. Signeture 23a. Part1. Er shock, of	-5137 De of Decedent 10b. County d Cecil. Number etchwood us Astried 2M Merrie ad 4 Divorced 15. Decedent' Specify only highest Secondery (0-12) me (First, Middle, L arnes s Neme/Relationsh a W. Star Disposition 5 Other (Sp of Funeral Service L	Starne give street er 6. Sex 1 M 2 C Road 12. Wes Arm 1 H Yee 's Education it grade comple Colle Colle Last) hip (Type, Print rnes/Wi 3 □ Removal	s Decedent led Forces? Yes 2 2X hes, Give or or Dates:	5 10c. City, E.1.k Ever in U.S. No	16a. Deced (Give I iife. D A	10f. Zip Code 21921 Vas Decedent of Yes, specify C Yes 2 N ent's Usual Octain of work do no NOT use ref assemble g Address (Street	Elkton ar If Under 24 H s Hours M f Hispanic Origin? then, Mexican, Pu o Specify: upation be during most of a red) 18. Mother's N Bessie	(Specify Yes or No erto Rican, etc.)	Dey 5 h 4c. County Ceci. th 4c. Factor 1915 10g. Citizen of W United 14. Race Blac Specify 16b. Kind of Bu Automol Manufa Maiden Sumem	Year TOUGO of Deeth 1. 9. Birthplaca (S Country) Virgini 10d. Insi 1 What Country? States a - American India k, White usiness/Industry bile cturer (e)	a ide City Lim
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Immediate Ca disease or cor resulting in de-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.									nd 21921	
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3 Suicide 6 Could not be determined 4 Homicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)							28f. Location	(Street end Numb	per or Rurel Route	e Number,	
27. Menner of Death 1 Montral 2 Accident sinvestigation 3 Suicide 4 Homicide 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Yes 2 No 28d. Date of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Date of Injury 28d. Date of Injury M 28d. Date of Injury M 28d. Date of Injury M 28d. Date of Injury Sec. Injury at Work? 1 Yes 2 No 28d. Date of Injury Sec. Injury at Work?							Ony or 10	wii, Ototoj			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piec (Check only one) 1 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piec one)							eca, and due to the ocurred et the time,	cause(s) and ma date end placa,	anner as stated. and due to the ca	ause(s)	
	and title of cartifier					29c. Lice	ense number		29d. Date signed	d (Month, Day, Yo	'ear)
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				leath (Item	23e) (Type I				110	140	
J. Ivallie allo	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)						of men	84	ENG.	Md	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** VIRGIE 4b. City, Town, or Location of Death TILGHMAN 29 2000 0445 /Medical 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** The Memorial Hospital Easton Talbot If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Hours Min 1□ M 2□ F 76 Yrs. Director MD. 220-03-9040 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ¥Yes 2 □ No MD. FEDERALDSBURG Direct CAROLINE 10e. Street and Number 10g. Citizan of What Country? 10f. Zin Code 8 Name 23a 3477 HOLLAND DRIVE 21632 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Yes 2 No 1 Never Married 2 Married natural, or Maryland 21215-0020 1 ☐ Yes 2 ▼No Specify: BLACK P 3 □Widowed 4 □ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) POSTAL U.S. GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Pages 1 and 2 should be and Mental CHARLES V. HAYMAN LILLIAN WARNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) artment of Health ar ortant: If from 27 is SHARON WEEKS/DAUGHTER 3477 HOLLAND DRIVE FEDERALDSBURG, MD. Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 Buriai 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Cemetery 8/5/00 Preston, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility DASHIELL FUNERAL SERVICES L SERVICES

EASTON, MD 21601

Approximata Interval Between Onset and Death 9 E. DOVER ST. the mode of dying, such as cardiac of 319 E. 23a. Part 1. Entar the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finai 1-2 hours disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Causa (Disass or Injury that initioled events resulting in death) Last and Box 68760. physician Due to (or es a consequence of) attending P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 Yss 2 No signed to Division of Vital Records, þ 24b. Wara autopsy findings Completed 24a. Was an autopsy available prior to completion of cause of death? performed? page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 3 Suicide 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 20 within 24 hours aft To the Funeral Di-completely filled in Certifying Physician: To the best of my knowledga, daath occurred at the time, date and placa, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and this of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Nama and addrays of person who completed cause of death (Item 23a) (Type, Print) Lawrence 606 Dutchman's Lane Easton, Maryland O. Bohan

DHMH 16 Rsv 6/95

Registrar

31. Date filed (Month, Day, Year)

AUG 0 2 2000

Virgie Tilghman

books

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

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No							

Physician									Death				eg. No.			
Physician	1. Decedan	t'a Nama (First, Middle	a, Last)									ata of Deat		Maria	3. Ti	ma of Death
	Michael Hampton Taylor										Month Day Year 1gust 8, 2000			01	:30AM	
/Medical Examiner	4a Facility Nama (If not institution, give street and number)						4b. City, Town, or Local						4c. Coun			
Funeral	Sacred Heart Hospital								Cumberland Allegany							
	5. Social Se	birthday)	If Unde						tata or Foraid							
Director		Social Security Number 6. Sax 7. Aga (In yrs. last bin 214-82-4852 14-82-4852 39						hder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (S. Country) Oct. 5, 1960 Maryla								
emal. Pages 1 and 2 should be filed within 72 hours after death with the Maryland equatment of Health and Mental Hygiene. reportant: if item 27 is marked other than "natural", or items 23s or 28s-t show ny injury or other traumetic event, the Medical Examiner must be notified at 66s. To Be Completed by Funeral Director	Usual Rasio	dence of Decedant						1		1	100	,	1700	110	1 9 1 0	i i i d
	10a. Stata 10b. County 10c. City, Town or Location												10d. fnsi	ide City Limit		
	Maryland Allegany Wester							nport					1 🛱 Yas 2 🛭			
	10e. Street and Number					10f. Zip Code						1	10g. Citizan of What Country?			
	209 Marsh Avenue							21562					United States No. 14. Race - American Indian.			
	11. Marital		Arm	12. Was Decedent Ever in U,S. Armed Forcas?			. 13. Was Decedent of Hispanic Origin? (Sp. If Yas, specify Cuban, Maxican, Puerto				to Rican	Rican, atc.)			ce - Amarican Indian, ick, Whita, etc.	
		var Married 2 Marri	lf Y	1 ☐ Yas 2 ☒ No If Yas, Giva		1 ☐ Yas 2 ☒ No Specify:			:				Specify: White			
		dowed 4 Divorced	Yas	Yaar or Datas:												
		15. Decedant (Specify only highes	'a Education	ucation 16a. Decedent's Usual Occupation (Give kind of work done during most of wo					st of wor	rking		16b. Kind of	Businass	/Industry		
	Elementa	ary/Secondary (0-12)	1	Collega (1-4or 5+)			(Give kind of work dona during most of working life. DO NOT use retired)									
		12		F			Florist				Self em				ployed	
		Name (First, Middla, I	Last)					18. Mother's Nam			ma (First, Middla, Maidan Surnama)					
	Ha:	rry H. Ta	ylor	lor				18	Mary Jean Mi			Mil	ller Taylor			
	19a. Inform	nant's Name/Relationsh	hip (Type, Prir	nt)	19	9b. Mailin	g Addras	s (Street	and Numb	er or Ru	ural Rou	ta Number	, City or Tow	m, State,	Zip Code)	
	Harr	y Taylor/	Fathe	r		209	Mar	sh	Aven	ue	Wes	tern	port	, MD	21	562
	20a. Matho	d of Disposition			20b. Place	of Dispos	sition (Na	ma of		T	Da	ta	20c. Location	n - City o	Town, Sta	ata
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	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Appro	ximata al Between					
Physician											Onsat	and Daath				
/Medical	Immediate Causa (Final															
Examiner	disease or condition rasulting in death) Endstage NonHodgkins Lymphoma 2 yrs.														0	
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and I-transit Xaminer	rasulting in	death)	a	Di		a conaeq	uance of)):	Lymj	phoi	ma				2	yrs.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MARGARET TOMPKINS 940 mm 200 AUCUST 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give streat and number) 4c. County of Death DORCHESTER GENERAL HOSPITAL DORCHESTER CAMBRIDGE 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2X F Months Days Hours Min. PENNSYLVANIA 164-12-9998 94 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No MARYLAND DORCHESTER EAST NEW MARKET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3607 GREEN POINT ROAD 21631 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILLIAM L. McNAMARA MARY (MAIDEN SURNAME UNKNOWN) 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 WILLEY ROAD, HURLOCK, MARYLAND 21643 KENNETH B. GENTRY/NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEM. 8/10/00 BEULAH, MARYLAND 21. Signature Funeral Service Licen 22. Name and Address of Fecility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631 Part / Entar the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Myoenschind I Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy performed? 1 Yes 2 - No 1 Yes Man 26. Plece of Deeth (Check only one)

Physician /Medical **Examiner**

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certificate

this

Physician

Examiner

Funeral

Director

"natural", or flares 23a or 28a-f show

altimore, Maryland 21215-0020

and Mental

Health

reportant: If Item 27 is marked

must be notifie

/Medical

Director

Funeral

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Completed

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burial-tra the ettending p signed b sete has been signated page 2 should b

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Hospital within 24 hours e To the Funeral C completely filled

To the

Examiner Physician/Medical þ Completed Be 2 al or Attending Physics efter death.

I Director: After this et in by the funeral d Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Yes 1 ☐ Inpatient → DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Waturat 5 Pending Investigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es steted.

2 Madical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifler and manner stated.

State Registrar

Medical

29b. Signature and titla of contill

302 31. Detained (Month, Day, Year) 32. Registrar's Signature

1 0 2000

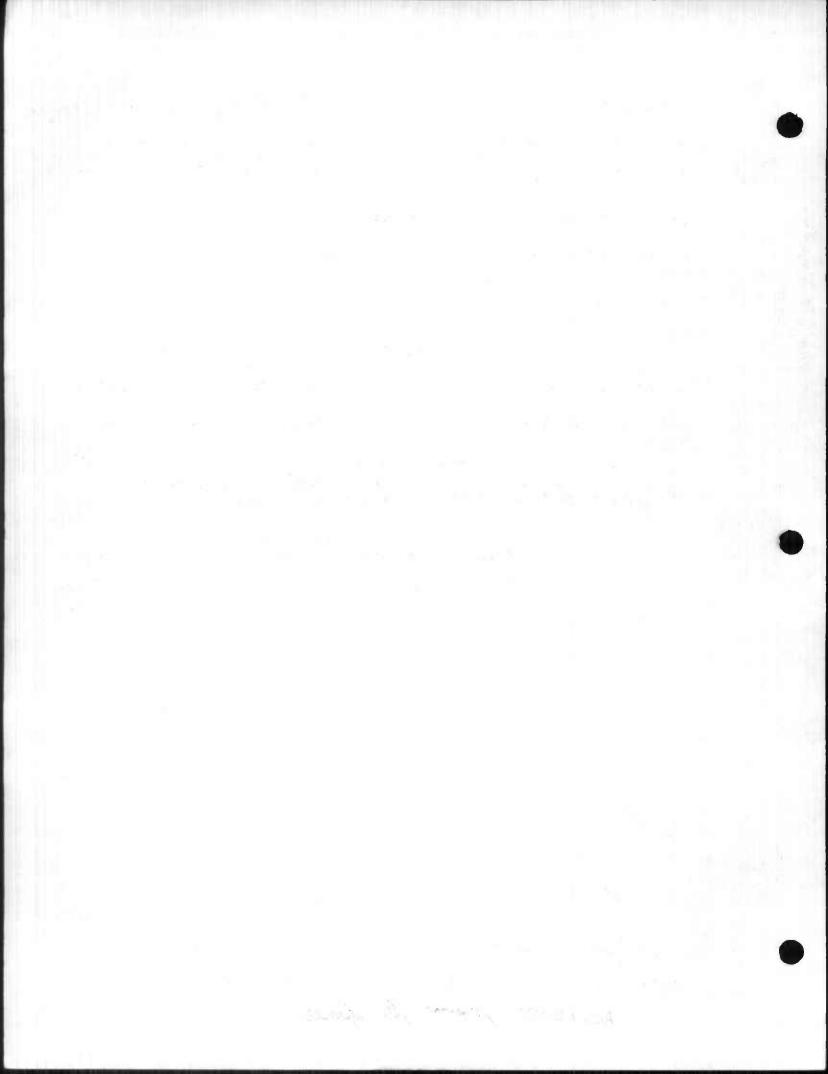
AUG

who completed cause of death (Item 23a) (Type, Print)

Collins.

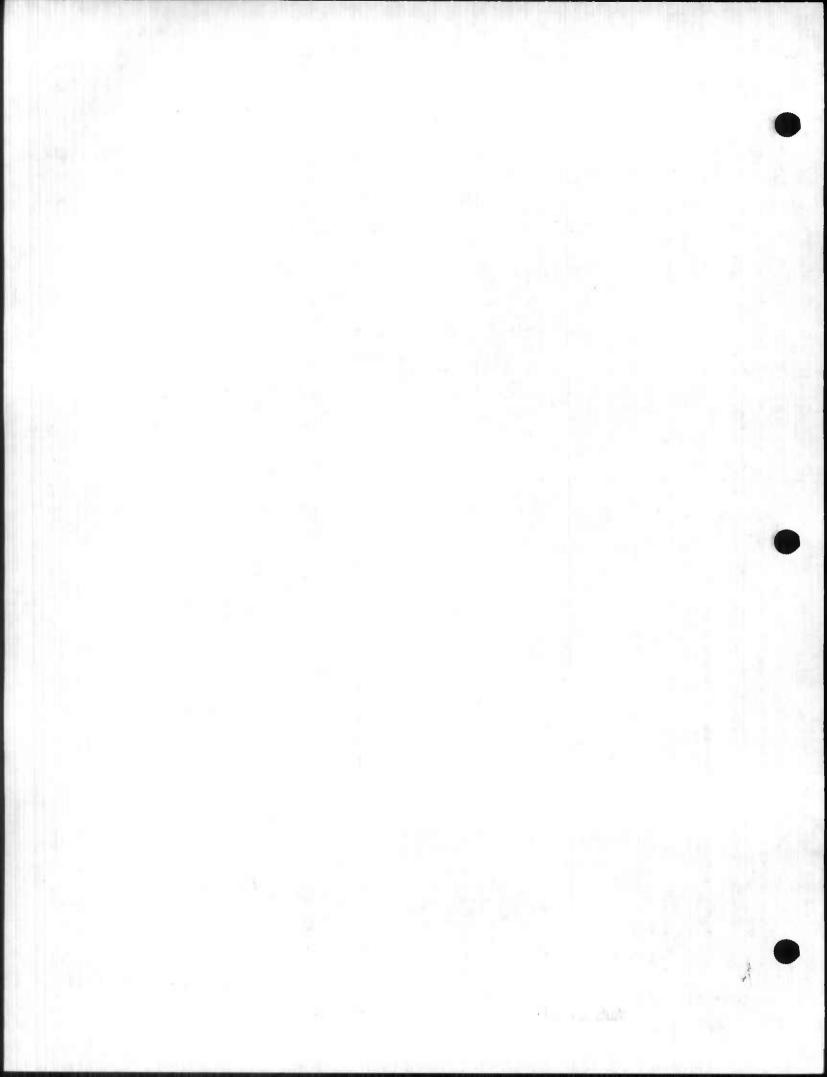
29c. License number

29d. Data signed (Month, Day, Year)



A TIA	ULRICH		State of Marylar	nd / Departme <i>Certific</i> e				giene	0 26573
	Physician	Decedent's Name (First, Middle, Las	Kevin Paul Ul	rich			2. Dete of Dec Month AUGUST		3. Time of Deeth 2000 17:19 PM
	/Medical Examiner	4a Facility Neme (If not institution, give			1	lb. City, Town, or L	ocation of Death		
		300 BLOCK OF MOU				PERRYVI	7		CIL
	Funeral Director	214 30 0741	ex 7. Age (In yrs. 34	Yrs. If Un Monti	der 1 Yeer ns Days	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da May 5,	1966	9. Birthplace (State or Foreign Country) Maryland
	2 2	Usuat Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location					10d, Inside City Limits
	tehe to	Maryland Cecil			Perr	yville			1 ☐ Yes ZONo
	or 25a-fa be notified Directo	10e. Street and Number		101.	Zip Code			10g. Citizen of V	Vhat Country?
100	al D	194 Mountain Hill	Road		2	1903		U	.S.A.
20	is and cean with the Marya if, or leves 23a or 25a-f sho carriner must be notified at by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Yeer or Dates:		cedent of H pecify Cubs	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Blace Specify	e - American Indian, sk, White, etc.
00-	DC 99 MAG	15. Decedent's Ed		16a. Decedent's U	suel Occup	ation	1	16b. Kind of Bu	usiness/Industry
215	od within 72 ho ygiene. ser than "natur 4, the Medical Completed	(Specify only highest gra-	de completed) Çollege (1-4or 5+)	(Give kind of life. DO NO	work done	during most of world)	king		
121	Con Con	1	1/2 years	Buildin	g Con	tractor			ction Industry
Maryland 21215-0020	B Total	17. Father's Name (First, Middle, Last)	ter Ulrich			18. Mother's Nam	ne <i>(First, Middl</i> e, rbara Ga		
7	d Men marks matter To	19a. Informant's Name/Relationship (7		19h Mailing Addr	ass (Street	and Number or Ru			
Ma	10 2 sh 10 4 m 17 is m 17 is m	Tracy Lynn Ulrich							Maryland 21903
re,	f Head	20e. Method of Disposition	20b.	Place of Disposition (cometery, crematory)	Name of		Date	•	City or Town, State
altimore	rages minimit my or o	1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify	Removal from State			-	8/19/00	West Ches	ter, Pennsylvania
Balt	Departs Imports any inju	21. Signeture of Funeral Service Licen	ther Dox Sr.	Lee A	. Pat	ss of Facility terson & , Marylan			me, P.A.
4	Physician /Medical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the compshock o	· Multipl		ries				Approximate the tribute and Death Onset end Death
	sicien and buriel-transit all Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b Due to (or as a consequenca	of):				
687	thysicie the bur	cause. Enter underlying Cause (Disease or Injury thet initieted events resulting in death) Last	c. Due to (d	or as a consequenca (of):				
Вох	e atten e atten e for u						OOL DIA		
P.0	by the tached	Part II. Other significant conditions or	ontributing to death but not re-	sulting in the underlying	ig cause giv	en in Part I.		Yes 2 No	ntribute to the cause of death? 3 Probably 4 Unknow
ords	been sign should be leted by						24a. Was perio	an autopsy rmed?	24b. Were autopsy findings svallable prior to completion of cause of death?
R	ate hes						1,00	Yes 2 No	1 DYes 2□ No
	certificate rector, pag	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)	
of	his his	Yes 2□ No	Hospitat: 1 ☐ Inpatient 2 ☐	1	DOA Oth	4 U Nursing H			er (Specify) SCENE
	After funer funer tion:	27. Manner of Death 1 Naturat 5 Pending investigation	28a. Date of tnjury (Month, Day Year)	28b. Time of Injury	28c. Injur	yat k? Yes 2.257No		how injury occur	accident
0	Mer deat Mector: In by the	2 Accident 3 Suicide 6 Could not be 4 Homlolde determined	D 12 1000	ome, farm, street, fac	1	100 2,23110	28f Location /	Street and Numb	per or Rural Route Number, Block Mountain H
	4 hours		yalclan: To the best of my known of the basis of examine and manner stated.	wiedge, death occur				cause(s) and ma	anner as stated.
	within 2 To the	29b. Signature and title of cartifier	1		29c. Licens	e number		29d. Date signe	d (Month, Day, Year)
	10	stysts.	d Vlac	5, M.D.	0.	C.M.E.		AUGUST	16, 2000
	NU	30. Name and address of person who			nn Ct-	reet, Bal	timom	Marrilan	A 21201
	State Registrar	31. Date filed (Month, Day, Year)	2 a dentz, 32. Registrer's Sign		Spou	4	CHIOLE,	ran.y.tdi	M ZIZUI

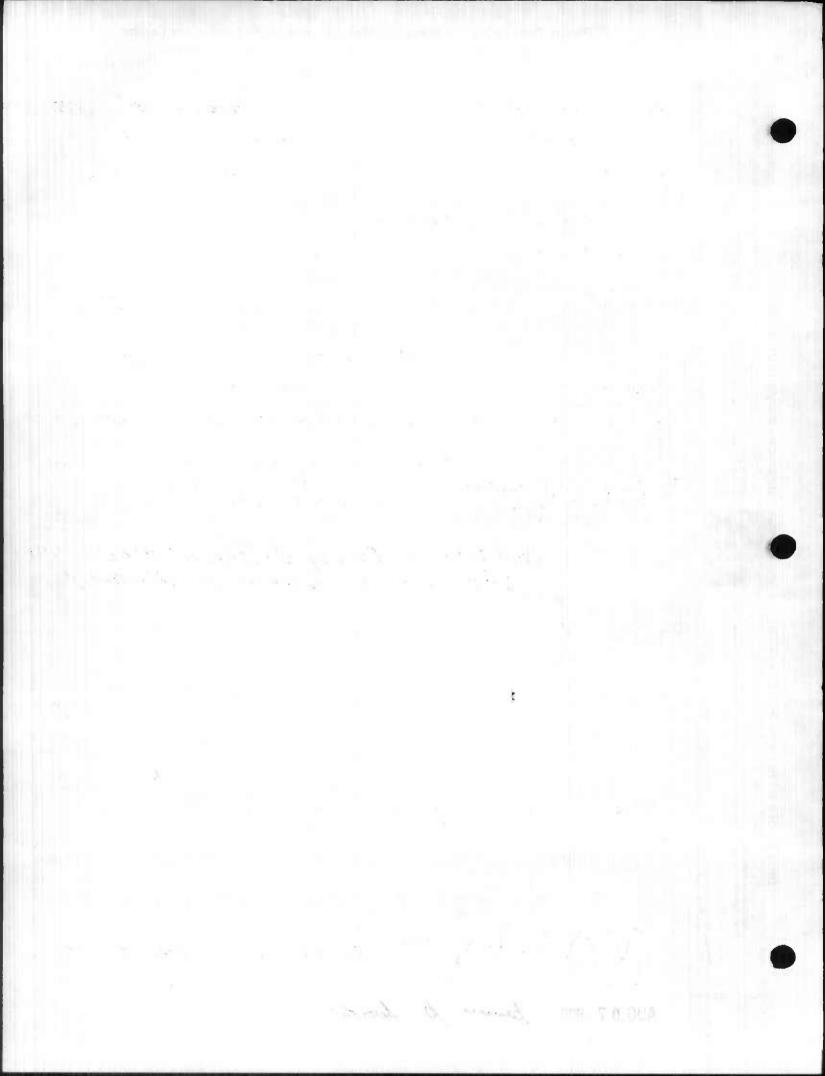
State Registrar



State of Maryland / Department of Health and Mental Hygiene 1 26571

				C	ertificate of	Death	A	leg. No.		0014
П	21	1. Decedent's Nama (First, Middle, La	st)	NAME OF			2. Data of Dea Month	th Day	Year	3. Time of live th
н	Physician /Medicai	WARREN HARDING	WASHINGTO	ON				4, 200		0857
	Examiner	4a Facility Nema (If not institution, given SACRED HEART HOSP				4b. City, Town, or CUMBERLA	Location of Death	4c. County ALLE	of Death	
	Funeral Director	214 12 3014	ax 7. Ag	a (In yrs. last birtho 79 Yrs	Months Dev			, Year)	9. Birthpl Coun MARYI	**
	pus *	Usuel Residence of Decedent 10e. Stete 10b. County		10c, City, Town o	Location				10	Od. Inside City Limits
	vith the Maryi or 28a-f sho be notified a	MARYLAND ALLEGA	NY	CUMBER						1 ☐ Yas 2¶]No
	after death with the Manylar or items 23a or 28s-f show the matter multiplian Funeral Director		VE S.W.			1502		U.S.	Α.	
21215-0020	E L	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forces? 1 X Yas 2 I I If Yas, Giva Yaar or Datas:		3. Was Decedant of If Yas, specify Cu 1 ☐ Yas 2 ☐ No		specify Yas or No- to Rican, atc.)	14. Rac Blac Specify	e - America ck, White, a v: BLA	atc.
5	ed within 72 ho ygiene. er than "natura ft, the Medical Completed	15. Decedent's Ed (Specify only highest gra		10	ecedant's Usual Occi	a during most of wo	rking	16b. Kind of B	usinass/Ind	lustry
121	within then the the then the then the then the	Elementary/Secondary (0-12)	Collega (1-4or 5	i+)	e. DO NOT usa ratir	ed)				
7				C.S	.X. RAILR	1	and African Adiabatic	RAILRO	11100	
Maryland	should be fi and Mental H marked out umatic avar To Be	17. Father's Nama (First, Middle, Last, ARTHUR WASHINGTO					ma (First, Middla, A BULLET		na)	
	d 2 sh th and 7 ls m traum	19a. Informant's Name/Relationship (JEAN F. WASHINGTO			ailing Address (Stree 24 OAKVIE					Code) LAND 21502
Baltimore,	5000	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specif		cematery,	sposition (Nema of cramatory or other po	AUGUST 8	Date 2000	20c. Location -		wn, Stata
Balti	permit. Page Department Important: If any Injury or phos.	2 Signalura of Funaral Sarvice Line	Levet -		22. Name end Add MERRITT-A 404 DECAT	ress of Facility DAMS FUNE	RAL HOME	P.A.		
	Physician /Medical Examiner	Immediata Causa (Final diseasa or condition rasulting in death)	MetAS	TATIC Dua to (or as a cor CINO	POOV (saquanca of):	ly di	fferer newn	nti An	tED md	Onset and Death Un K
Box 68760,	aath certificate be executed attanding physician and for use as the bunat-transit claryMedical Examiner	Cause (Disaasa or Injury that initiated events rasulting in death) Last	c	Dua to (or as a cor						
	daath daath d for	Part II. Other significant conditions of	ontributing to deeth b	ut not resulting in th	a undariying causa (given in Pert I.	23b. Did to	obacco use co	ntributa to	the cause of death?
a .	that the da led by the a detached t						1 🗆 Y	res 2□No	3 Prol	bably 4 Unknow
Vital Records,	been sign should be						24a. Was a perfor	an autopsy med?	avi	ara autopsy findings ailabla prior to mplation of causa death?
Re	The law ate has b paga 2 s						1 D Y	as 2 XNo]Yas 2□ No
ā	certificate rector, page Co	25. Was case refarred to medical				26. Plece of De	ath (Check only or			3.100
>		axaminar?	Hospital:	nt 2 ER/Outpa	atient 3 DOA	lther	doma 5 ☐ Resid		nar (Specifi	v)
on of	After fune	27. Manner of Death 1 Natural 5 Panding 2 Accident investigation	28a. Data of inju (Month, De	ry 28b. Tim	a of 28c. In		28d. Dascribe h			
Division	tal or Attending Pi is after death. In Director: After the ed in by the funera Certification:	3 Suicida 6 Could not b datarmined	28a. Place of Inj building, at	ury - At homa, farm c. (Spacify)	, straat, factory, offic	В	28f. Location (S City or Tow	itraat and Numl n, Steta)	ber or Rura	I Route Number,
	Hospita 24 hount Funera laty fille		ysician: To the best of the basis of and mannar sta	axamination and/o						
	within 2 To the comple	29b. Signature and little of cadifier	EM	MI	^	175 6	> 8	29d. Data signa	4 ,	Day, Year) 2000
	20, 1	30. Name and address of person who	completed cause of d	(Item 23a) (Ty	pe, Print)					
	Mis	DR ROBERT E. RAI	-		RIVE CUMBE	RLAND MAF	RYLAND 2	1502		
	State Registrar	31. Data filad (Month, Day, Year) AUG 0 7 2000	Ser Hagistr	ar's Signature	Spark					

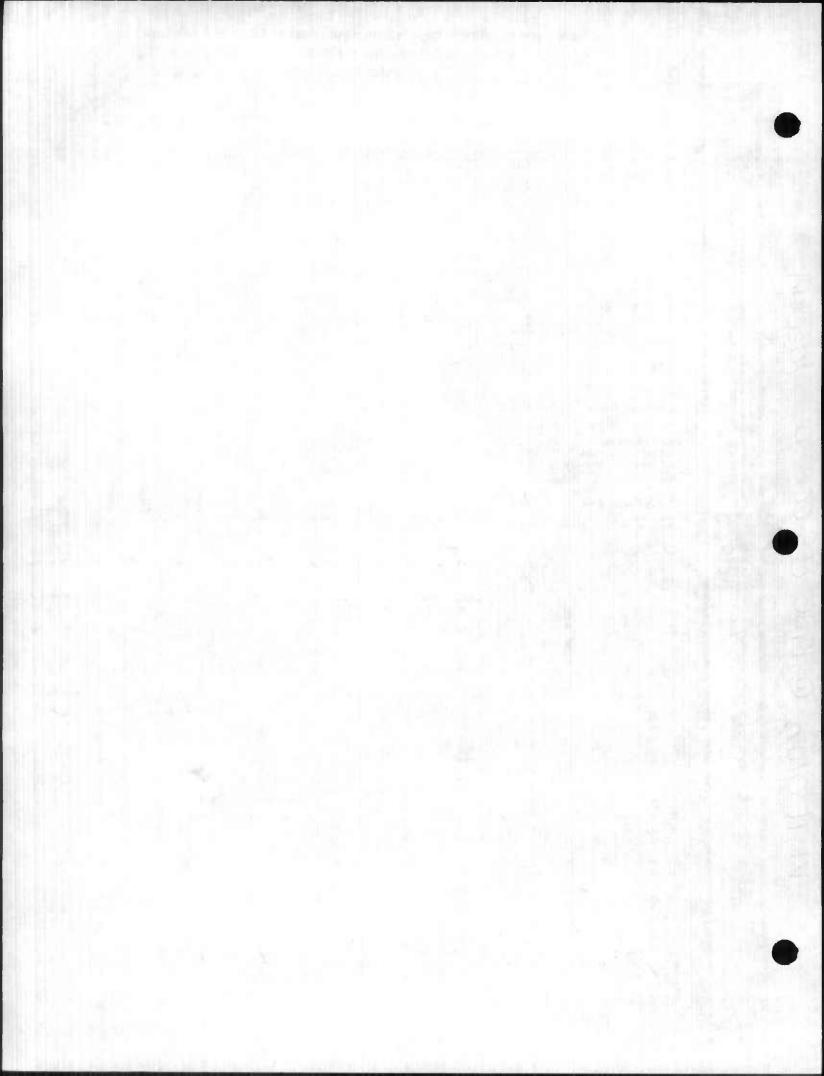
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State of Maryland / Department of Health and Mental Hygiene

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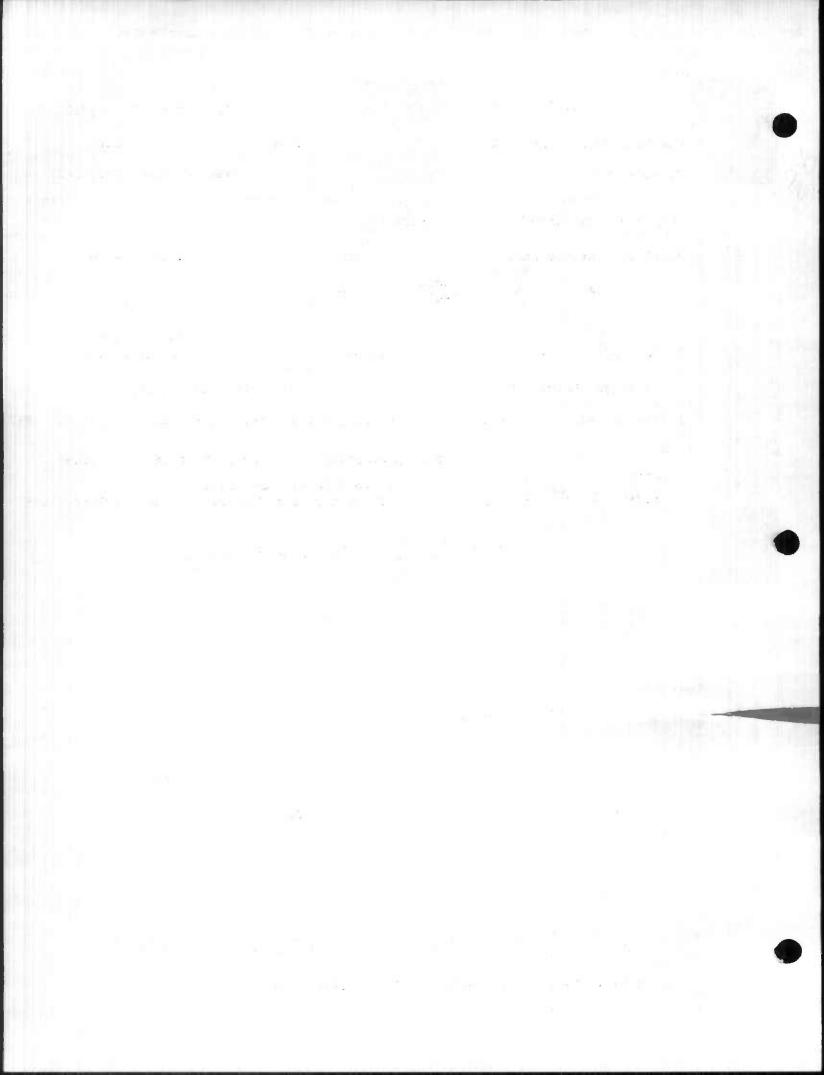
			Certi	ficate of	Death		Reg. No.	0 20070
Physician	1. Decedent's Name (First, Middle, Last)					2. Date of Do	Pay o	3. Time of Death
Physician /Medical	112111	EAN WAI				August		000 7:30 PM
Examiner	4a Facility Name (If not institution, give s Southern Maryla		L		Clin		Princ	e Georges
Funeral Director	5. Social Security Number 218 – 78 – 7550 6. Sex	7. Age (In yrs. I.		ff Under 1 Year Months Days	Hours M	8. Date of Bi Menth, Di Ovember	rth 4,1958	Birthplace (State or Foreign Country) NC
2 .	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loca	tion				10d. Inside City Limit
od and	MD Charles	1	ite Pl					1 Yea 2 N
or 28s-f.	10e. Street and Number	, WIII	ree ir	10f. Zip Code			10g. Citizen of WI	41
					0.5			at County:
era era	9160 Genevieve I		S. 13. Wa	206		(Specify Yes or N	USA p- 14. Rece	- American Indian,
ar, or here 23. Example: ment	1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yea 2 No	Specify:	(Specify Yes or Ne erto Rican, etc.)		White, etc. White
ated pted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deceder	nt's Usuel Occup	ation during most of w	vorkina	16b. Kind of Bus	
ygiene. wer then "maturity, the Medical	Elementary/Secondery (0-12)	College (1-4or 5+)		of work done NOT use retired ator M			Unio	n or Contract
	12		FIEA	ator H				
B vote	17. Father's Name (First, Middle, Last)						, Meiden Sumeme	,
d Men marks marks	Donald Wall 19a. Informant'a Name/Relationship (Ty)	an (Print)	10h Mailinn	Addraga (Ctuant		ed Wall	ber, City or Town, S	State Zin Code)
THE PARTY OF THE P	Donald Wall/Fath						,MD 206	
Heart 2	20a. Method of Disposition			ion (Neme of tory or other plea		Date		City or Town, State
family or of	Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State Tr:	inity	Memori	al Gar	8/14/0		rf,Marylan
Depar impor any in	21. Signature of Funeral Service Licenses	Ehol Moog			T-ECHO		RAL HOM	
physician and street transit the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last	as	as a conseque as a conseque					unknow
attending for use a	Part II. Other significant conditions con	tributing to death but not resu	liting in the und	erfying cause giv	ren in Part I.			tribute to the cause of dea
been signer should be d						24a. Wa	s an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of death?
page 2						150	Kes 2□No	1 Yes 2 No
certificate rector, pag	25. Was case referred to medical				26 Place of C	Death (Check only		10.103 20.110
	examiner?	ospitel: 1 Inpatient 2	ER/Outpatient	3 DOA Oth	ar.		sidence 6 Othe	r (Specify)
ther this meral meral	27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injui Wor M 1	y at rk? Yes 2 □ No	28d. Describe	how injury occurre	pd
within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	me, farm, stree	it, factory, office			(Street and Number own, State)	r or Rural Route Number,
n 24 hours n 24 hours ne Funera pletely fille edical C	29a, Certifier Check only 2 Manual Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	viedge, death o ion and/or Inve	occurred at the tir stigation, in my o	me, dete and pla opinion, death oc	ice, and due to the courred at the time	cause(s) and man , dete and place, a	nner as stated. nd due to the cause(s)
Withir Comp	29b. Signature and attend certifier	ale.	MIL IN	29c. Licens	e number		29d. Date signed	(Month, Dey, Year)
3 14 18	1 Halv	Willen		1)5	0450	1	Augu.	1 10220
	30. Neme and address of person who co	pleted cause of death (Item	23a) (Type, Pr	int)		1	/	, , , ,
	Arastoo Yazdani	,MD 7700 O	ld Bra	nch Av	e. Cli	nton.MD	20735	
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signat		. /				
Registrar	ALIC 19	7000 heres	-	1 100	1			



	1	Decedent's Neme (First, Middle	l act)		00	rtificate of	Dealli	2 Date of De	Reg. No.	- Ema	0 0 1 0
lan	ľ			W = 4 ==				2. Dete of De Month	Dey	Yeer	3. Time of De
ical	40		Edward 1					Augus			9:35 I
iner		e. Fecility Neme (If not Institution,					4b. City, Town, or I	ocation of Deat			
		Caroline Nursin			to a deficiello of a col	If Under 1 Year	Denton If Under 24 Hrs.	Ta Di vini		roli	
!		and the same of th	6. Sex 1⊠ M 2□ F	7. Age (in yrs. la		Months Deys		(Month, De	ay, Year)		plece (Stete or Fintry)
	-	217-24-3993 suel Residence of Decedent		/	4 Yrs.			January	27, 1926	Mai	ryland
		Da. Stete 10b. County		10c. City	, Town or Lo	ocation				1	Od. Inside City I
jo	1	Maryland Caro	line	F	edera	lsburg					1 Yes 2
Director	-	De. Street end Number	11110		cuci u.	10f. Zip Code			10g. Citizen ot \	Whet Cour	ntry?
		28115 Bridgevil	10 Pond			21632					•
lera	-	1. Merital Stetus		edent Ever In U.S	S. 13.			pecity Yes or No	United	a - Americ	
Funeral		1 Never Married 2 Marrie	Armed Fo	orces? 194	-0-		Hispenic Origin? (S pan, Mexican, Puert	Rican, etc.)	Ble	ck, White,	
by		3 ☐ Widowed 4 ☐ Divorced	ed 1 Ves If Yes, Gi Yeer or D	ve 194	7	1 ☐ Yes 2 ☑ No	Specify:		Specify	y: lucas:	ian
Completed		15. Decedent's	s Education		16e. Dece	dent's Usuel Occu	pation		16b. Kind of B		
pie	-	(Specify only highest Elementery/Secondery (0-12)	t grade completed) Coilege (1-407.51)	(Give	kind of work done DO NOT use retire	during most of wor ed)	king			
E O		11 HS Grad	1	1-401 3+)	1	Police			Law Enf	orce	ment
Bec	17	7. Father's Neme (First, Middle, L	ast)				18. Mother's Nan	ne (First, Middle	, Maiden Sumen	ne)	
10		William Ha	rold Wei	ir			Mary	Estelle	e Duffe	Y	
	15	9e. intorment's Neme/Reletionsh	ip (Type, Print)		19b. Malii	ing Address (Stree	t end Number or Ru	ral Route Numb	er, City or Town,	Stete, Zip	Code)
	I	Billie A. Weir	Wit	fe	2811	5 Bridge	ville Roa	d, Fede:	ralsburg	, Mai	ryland 2
	20	De. Method of Disposition			lace of Dispo	osition (Name of metory or other ple	2001	Dete	20c. Location	City or To	wn, Stete
		1 Donetion 5 ☐ Other (Sp		21616		Cemetery	-	8/13/00	Denton	. Mai	rvland
	2	Signature of Funeral Service L	**			2. Name end Addr		0, 13, 00	Dencon	i, iidi	Lyland
		6 Kay Orhlit	9 00-				neral Hom				
	In	39. Perti. Enter the disease, or of shock, or heert teilure. Liet of the shock of t		,	. Do not en	ter the mode ot dy		or respiretory e	errest,	Mary	Approximete Intervel Between
Examiner	In di re	mmediate Cause (Final isease or condition assulting in death)		diop.	. Do not en	ter the mode of dy		or respiretory e	errest,	Haly	Approximete Intervel Between
dical Examiner	In di re	mmediete Ceuse (Finei iseese or condition esulting in death)		Due to (or	a Ric	quence of):	ing, such es cardiec	or respiretory e	errest,	Haly.	Approximete Intervel Between
dical Examiner	In di re	inmediate Cause (Final issesse or condition assulting in death) equentially list conditions, any, leading to immediate ause (Disease or Injury let initiated events assulting in death) Lest	e. <i>I</i> b	Due to (or	a. Do not en	quence of):	m bocyt	or respiretory e	orrest,		Approximate Interval Batwar Onset and Dec
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Baltimore, Maryland 21215-0020

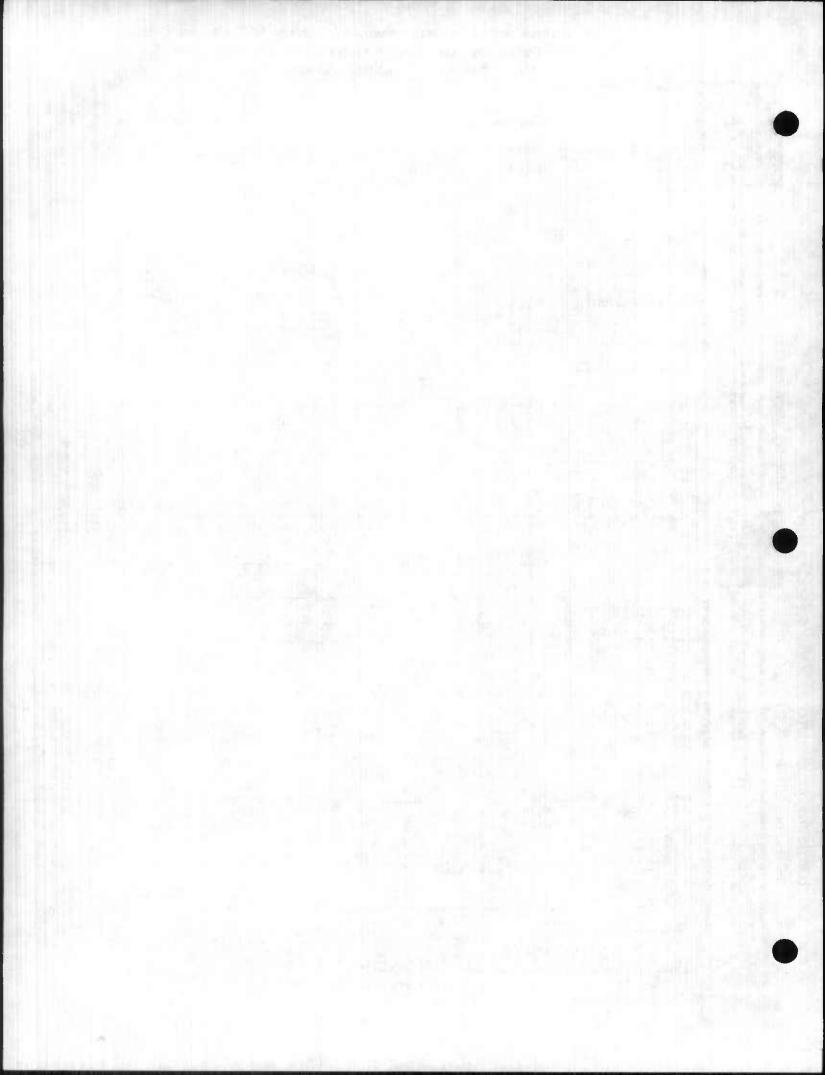
Division of Vital Records, .O. Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25577

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Yaar **Physician** ERNes. 2000 8:15 PM AUGUST /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PERRY POINT VA MARYLAND HEALTH CARE SYSTEM If Undar 1 Yaar 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 15 M 2□ F Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 2/5-22-1383 Usual Residence of Decedant Director 10a. Stata 10c. City, Town or Location 10d. inside City Limits Cecil EIKTON 1 ☐ Yas 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21921 45.A 2230 0/0 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican indian, Black, Whita, atc. 11 Marital Status 2 Married 1 Ayas 2 No W Yas, Giva 1 ☐ Yas 2 No Specify: Specify: 3 Widowed 4 Divorced Yaar or Datas: WW II white 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) LAB Technician Thio Kol 12 Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) Be 8 Barbara Scott AR WARD 4nch 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) SON Ernesi 8/11 altimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Mem. PK Donation 5 ☐ Othar (Specify) Manar 21. Signature of Funaral Service bicense 22. Nama and Addrass of Facility tuneral Home 23a. Part 1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cebse on each line. Approximata Interval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) KNKNOW N Examiner Examiner Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last Dua to (or es a consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequanca of): or Attending Physician: The law requires that the death certificate Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown ANCER OF STOMACH Division of Vital Records. Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? MULTIPLE ABDOMINAL METASTASIS 2 10 No 1 Yas 2 No 25. Was case referred to medical axaminar? 26. Placa of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 Impatiant 2 ER/Outpatient 3 DOA this 27. Menney of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 1 Netural 5 Panding invastigation 1 Yes 2 No death. 2 Accidant within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner statad. edicai 29a. Certifiar ş 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) VA MARYLAND HEALTH CARE SYSTEM PERRY POINT, MD NAIR, U.D. KARMACHANDRA 31. Data filed (Month, Day, Year) 32, Registrar's Signatura State AUG 9 9 2000 Registrar DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** LAURA V. WALMSLEY 10.00 P.M AUGUST 2000 10. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARE FACILITY ELKTON LAURELWOOD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1□M 2☑F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 218-40-0613 JANUARY 1, 1914 Director MARYLANI Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f show 1 No 2 No Director MARYLAND CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 23 MONTGOMERY LANE 4.5 A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dales: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE DRODUCT le merked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 end 2 should be filk Department of Heelth and Mental Hy Important: If Nem 27 Is marked oth any Injury or other treumatic event one. ROBERT GOOD YEAR MARGARET SIMPERS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 23 MONTGOMERY CAME ELKTON, MS 21921 NIECE PATRICIA COMER 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 8/14/00 WEST CHESTER PA PA FEREIS INC 4 ☐ Donation 5 ☐ Other (Specify) GEE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL HOME 259 E. MAINST. BKTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear fallure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ent-Stage Renal Disease
Due to (as a consequence of): 6 MONTHS Examiner Examiner > 10 years HyperTension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of) Box (P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus - Type Z Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy Cerebrovoscular disease 1 Type 2 This 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this cartifica completely filled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Inpatient 5 | Residence 6 | Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Monte Makons, MO August 11, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MONTE MAKOUS, MO

31. Date filed (Month, Day, Year)

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Sports

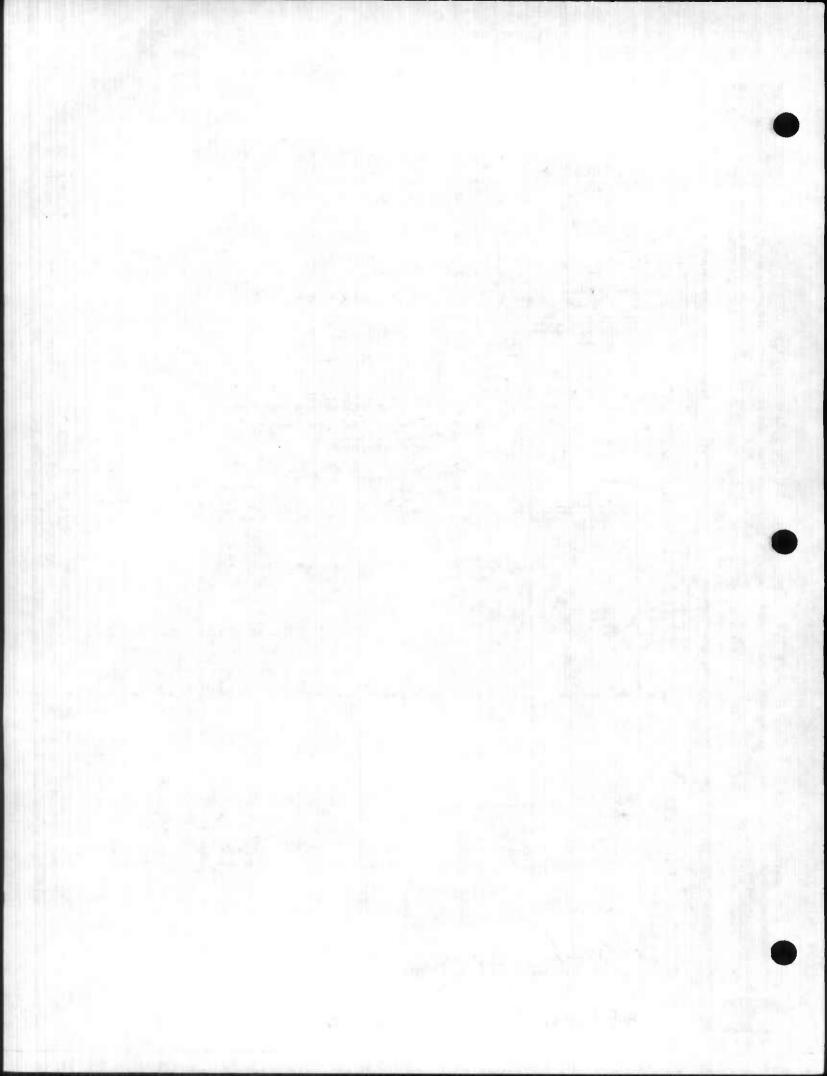
32. Registrer's Signature

111 West High street, ELKTON, MD 21921

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State of Maryland / Department of Health and Mental Hygiene

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	or 28a-l	Directo	10e. Street and Number	E11	CION	10f. Zip Code				10a. Citizen of	What Cour	ntry?
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_	The Control	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	1	Yes, specify Cut	an, Mexican	Puerto	Rican, etc.)	BI	ack, White,	etc.
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0	g Phys er this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of					how injury occ	-	
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VIS	ar de	tific	3 Sulcide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	14-1-1		28f. Location (Street end Nun	nber or Rure	al Roule Number,
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	To the Hospital or Attentwithin 24 hours after deal To the Funeral Director: completely filled in by the	edicai		ician: To the best of my knower: On the basis of examinat								
	the H		one)	and manner stated.	ion and or in			iii occuri	ou at the time,	Oate and place	2, and 000 to	0 (110 00000(3)
	With To To	Σ	29b. Signature and title of certifier			29c. Licen	se number			29d. Date sign	ed (Month,	Day, Year)
	. 5		1 yerro	1, 17		11	5 7/	4		Aug 1	6,20	000
	10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	11-			, /		
	1		H Farkes, MD	Union Ho	spit ay	E	Ik Ten,	1	70			
	Sta		AUG 1 6 2000	32. Registrar's Signal	ure 4	100 -	,					
	Registr	di	HOU 1 0 2000	141-	1.	1900LG	2					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WAShKEVICH AugusT 1722 Michael JOhn 2000 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) HARford Memorial Hospital HAURE de HARford Union GRACE 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex Days Hours 104M 20 F 220-36-200 Usual Rasidance of Decedant 100 MAY 24, 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ùOKyas 2□No Perryville d Cecil 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 400 Craighill Channel Drive West 21903 U.S.A. 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) l ☐ Yes 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) Fleming Industry College (1-4or 5+) Four Years Elemantary/Secondary (0-12) Payroll Clerk North East, Maryland 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) John M. Washkevich Doris Chesser 19e. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve G. Washkevich (wife) 400 Craighill Channel Drive West, Perryville, MD 21908 20b. Plece of Disposition (Nema of cematary, crametory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2XX Cramation 3 ☐ Removat from State R.A. Ferris & Co., Inc. 8/17/00 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funaral Sarvice Licenses homas In. tallerson, Sr. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final 24 HRS COAGULOPATIOY diseasa or condition rasulting in death) Due to (or as a consequence of): CASTROIN TESTINAL Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last CALCINOMA UNKNOW Part II. Other eignificant conditions contributing Io death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Wara autopsy findings available prior to completion of ceusa of deeth? 24a. Was an autopsy performed' 1□ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Mengar of Death 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida

Jeh. of or Attending P after death. Director: After t Division To the Mospital of within 24 hours at To the Funeral Completely filled

Physician

/Medical

Examiner

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Director

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Baltimore, Maryland 2121

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Health Item 27 I

Physician /Medical

Examiner

Physician/Medical Examine

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Be Completed

Medical Certification: To

29a. Certifier

29b. Signatura and title of certifie

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State Registrar

Dr. Amelite 31. Date filed (Month, Day, Year) AUG 1 7 2000

30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print)

Callas 32. Registrar's Signature

Lewis St. Have de Grace Md 21078 504

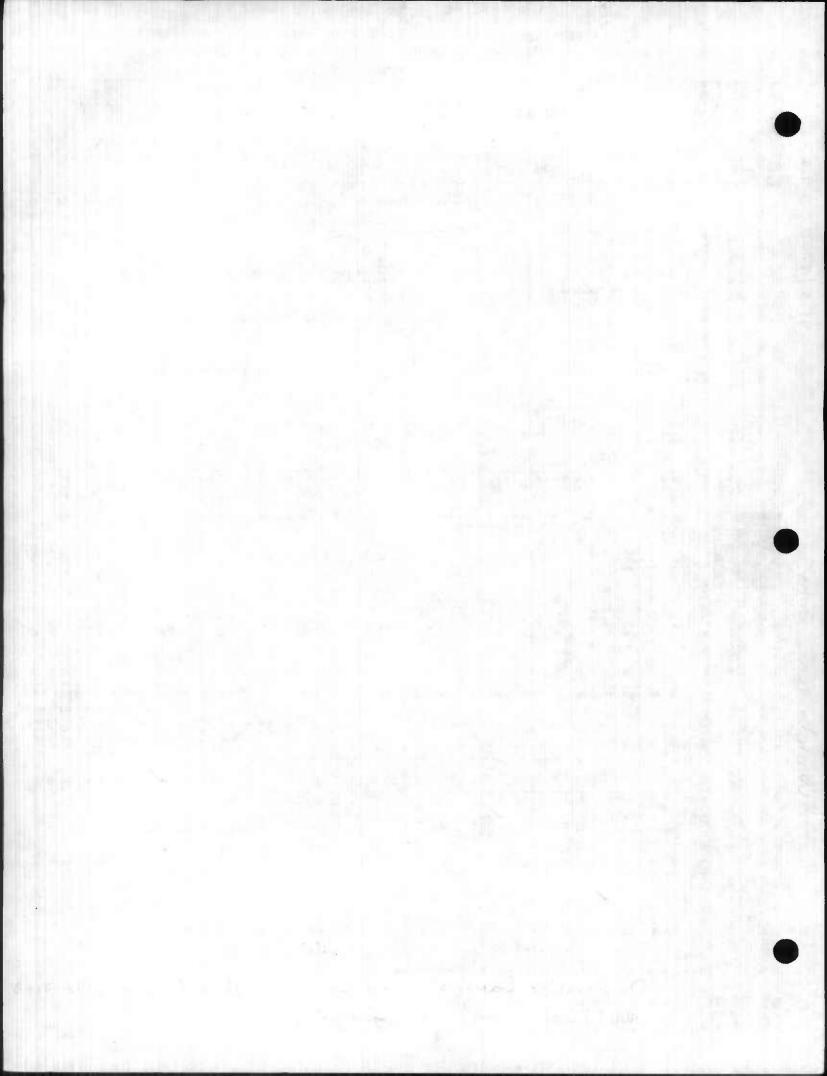
15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

(2)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** Timothy C. Zello August 11, 2000 12 noon /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 199 Weaver Meadows Road Conowingo If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** 10XM 20 F Deys Months 192-44-9932 48 Director 27, 1951 Pennsylvania Usuel Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flams 23s or 28s-f show traumstic avent, the Medical Examinar must be notified at 1 Yes 2 No Directo Maruland Cecil Conowingo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 199 Weaver Meadows Road 21918 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Merital Status Black, White, etc. 1 ☐ Never Merried 2 M Merried Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: À 3 ☐ Widowed 4 ☐ Divorced White. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Director of the Completed permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiere. Important: if Itam 27 is marked other than "nat, any injury or other traumatic avent, the Modest pages. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Directorate of Instruction Government 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Pete C. Zello Mary Cyktor 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen A. Zello 199 Weaver Meadows Road Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) Rosebank Cemetery 8-15-00 Rising Sun, Maryland 21. Signature of Foneral Service Licenses R. T. Foard Funeral Home, P. A.

111 S. Queen St., Rising Sun, MD 21911

Itions that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast,

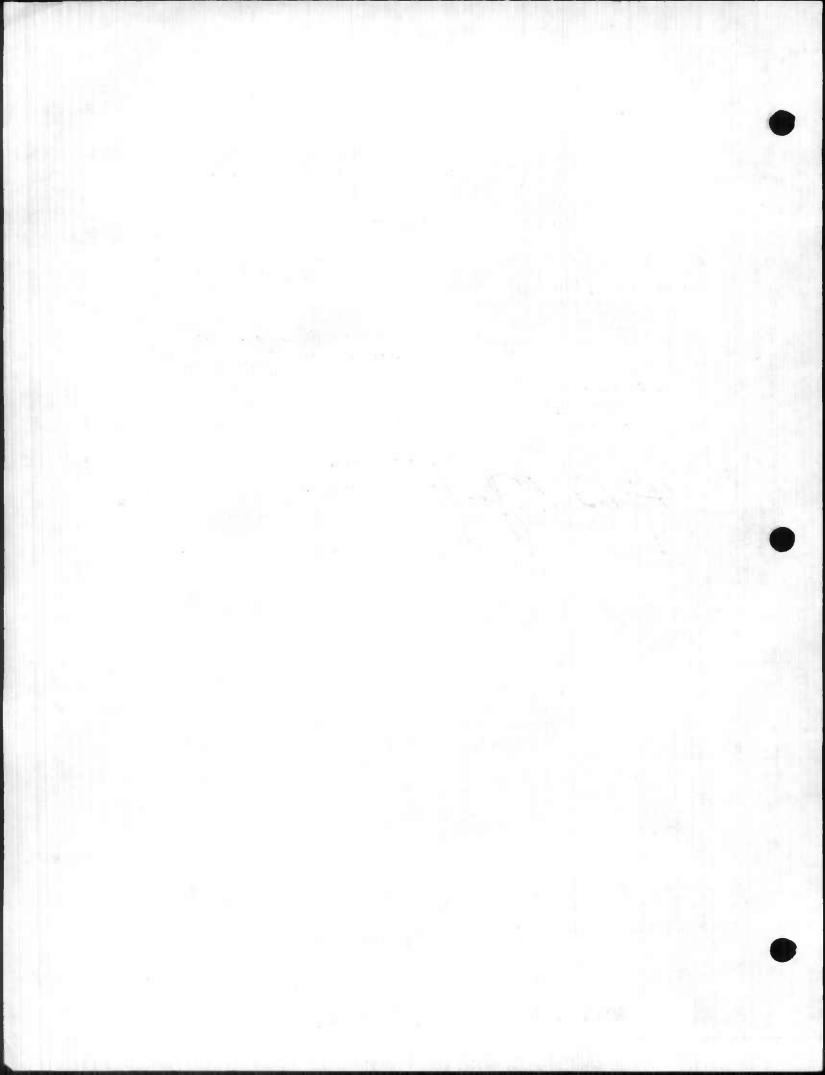
cadase on each line. 22. Neme end Address of Facility uchas 23a. Part . Enter the disease, or complice shock, or heart failure. List only one Approximata Intervel Between Onset and Death **Physician** CELL CARCINOMA of TONGUE Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) USB Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by to 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings availabla prior to complation of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural Attanding To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred et the tima, data end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred et tha time, data end place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) MAR and addrass of person who completed causa of death (from 23a) (Type, Print) 2 OAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rav 6/95

Registrar

AUG 1 5 2000

Bane



State of Maryland / Department of Health and Mental Hygiene 00 26583

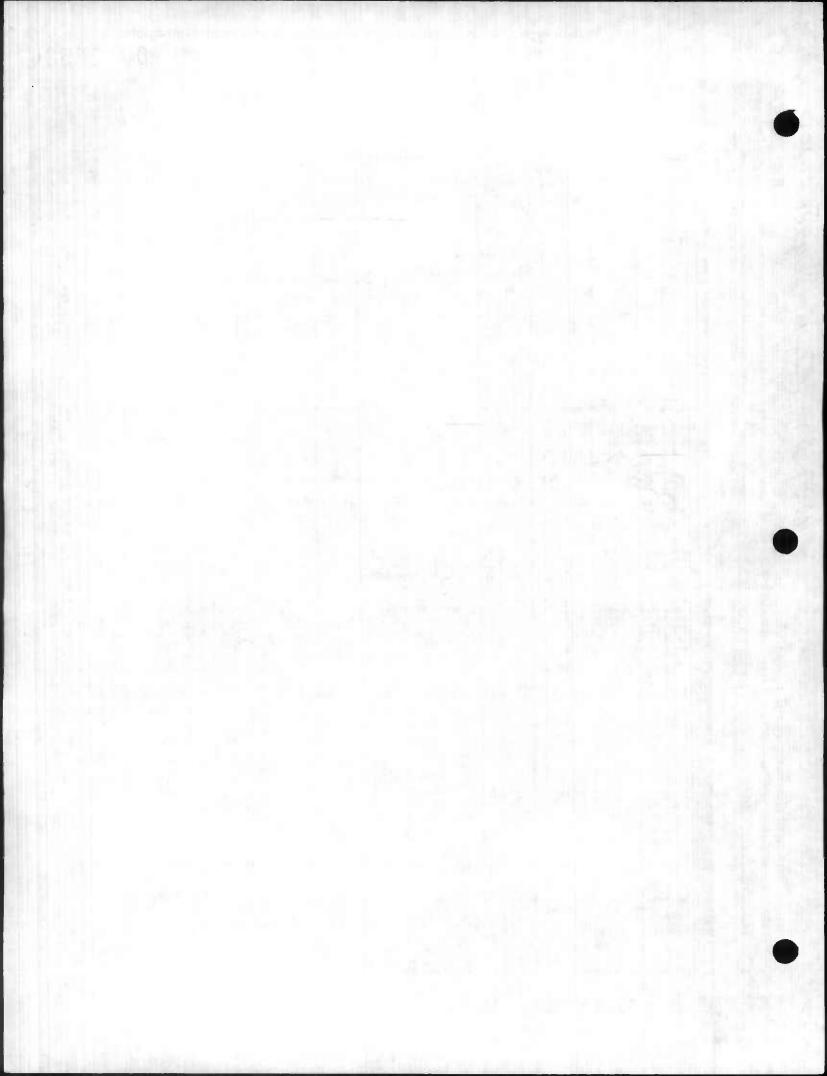
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within To the comple	29b. Signature and tit	le of certifier	1	1		2		a number			29d. Date signe		
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4	Theodore 31. Data flied (Month,			Registrar's Sig		enn	Stree	et, Ba	altin	nore, M	laryland	2120	1
State Registrar	31. Data med (Month,		3 2000		gnature.	4.	la	21/2	,				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND#19A PER INFMNT G787 9-26-00 State of Maryland / Department of Health and Mental Hygiene 26584 Amended Items# 10b&20a per FD g786 8-23- Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** JOSEPH Michael 10:45 PM. AUG. 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Bartmore HOSPICE GILL CREST If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 265-90-9252 Days 18 M 20 F FLORIDA Director Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Howard Counnty 10d. fnside City Limits 1 Yes 2 No Md. Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DRIVE 21045 1 amar U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2000 Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I,B.E,W Elementary/Secondery (0-12) Coilege (1-4or 5+) E/ectrician LOCAL 17 1245 44151 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Kosa unknown Flowers 19a. Informant's Name/Relationship (Type, Print) EX-WIFE 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, State, Zip Code) Columbia, md. Carmina Ortagus Allyson - WHEE 5917 Tamar 21045 DRIVE lam 27 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Description | 2 Description | 3 Description | 2 Description | 3 Description 8/23/00 Catonsville METRO Crematory 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee Lewis T. Gwynn Lews T. Guynn Freneral Home 4517 Parkheights Are, Balto, and. w 2,2,5 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CANCER Lung months Due to (oras a consequence of) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or es e consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Be Completed 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) HO S 1 Yes 2 No 2 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28b. Time of Injury at Work? or Attending P after death.

I Director: After the in by the funera 5 Pending investigation Netural Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral L 29e Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d Dete signed (Month, Day, Year) 29b. Signature and title of certific who completed cause of death (Item 23a) (Type, Print) Chan 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**

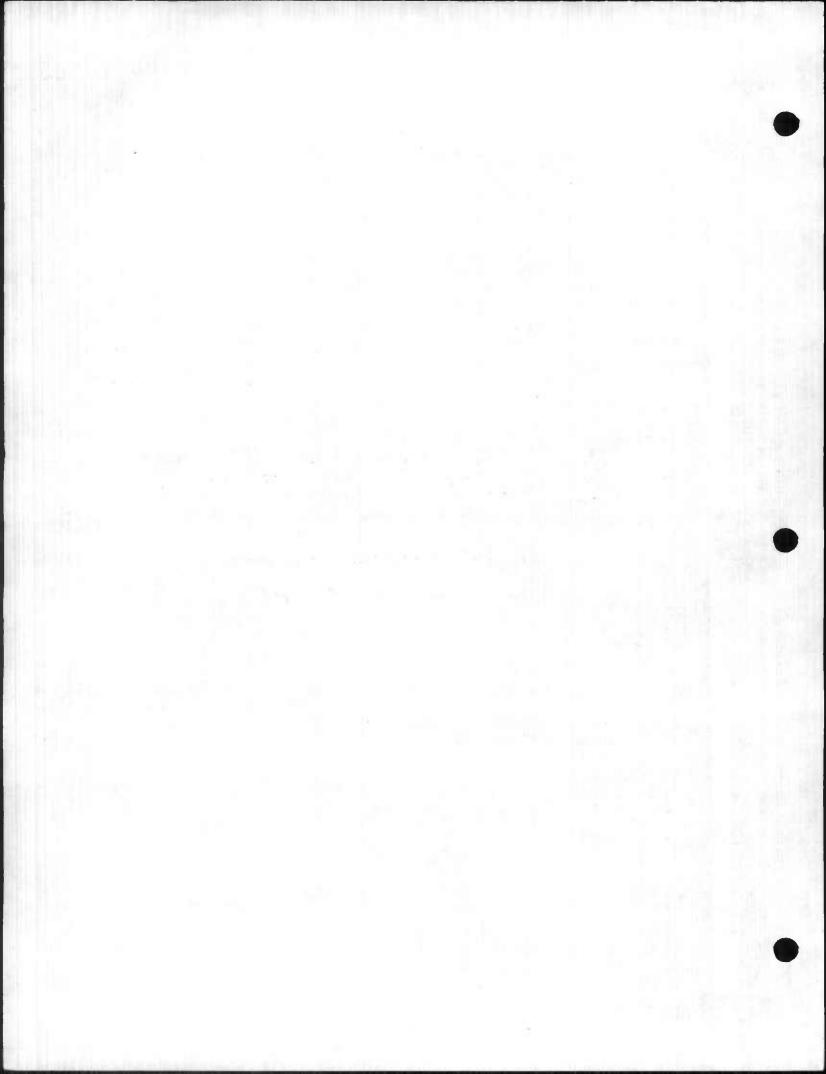
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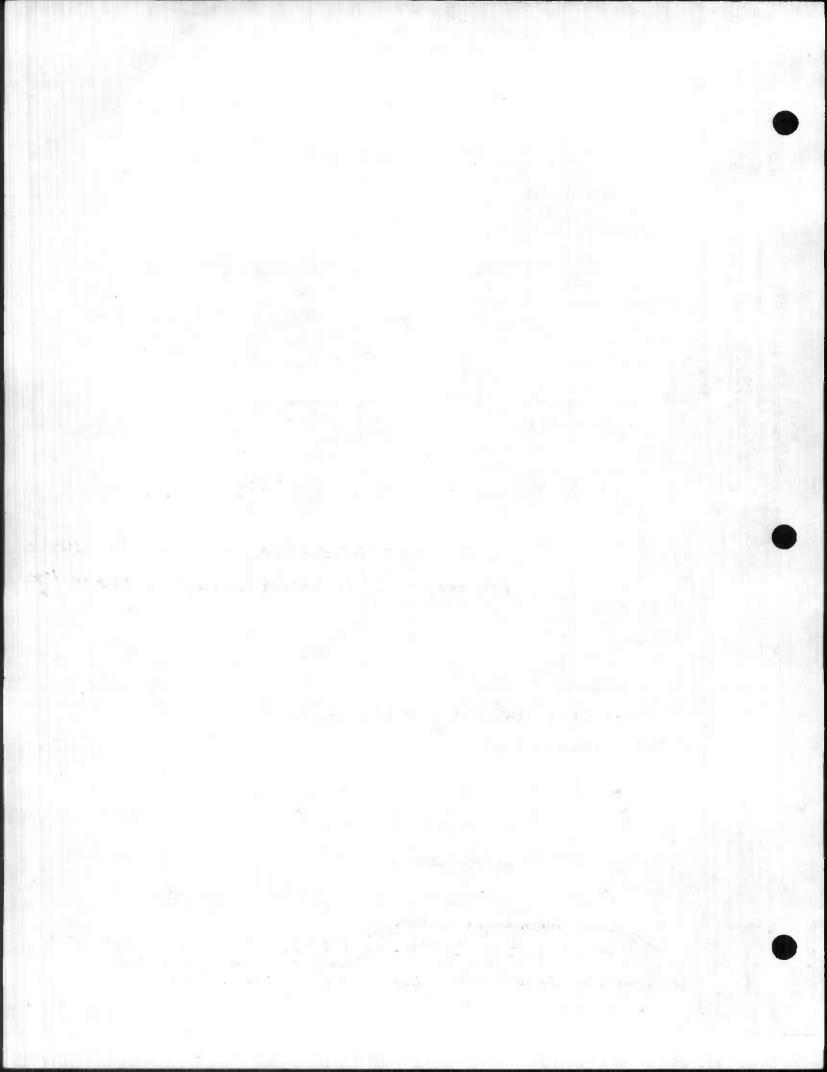
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10	Usual Residence of D 10a. State 1	Decedent 10b. County	100	. City, Town or I	ocation		1100.0000		10	d. Inside City Lie
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at be notified al Director					10f. Zi	ip Code 21061	(et	10g. Citizen of U.S.A		ry?
Examiner must by Funeral	3 Widowed 4	d 2 Merried	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S. 13 1952- 1954		edent of Hispanic Origin? ecify Cuban, Mexican, Put No Specify:	(Specify Yes or I erto Rican, etc.)	No- 14. Rad Ble Specif	ce - America ck, White, e	tc.
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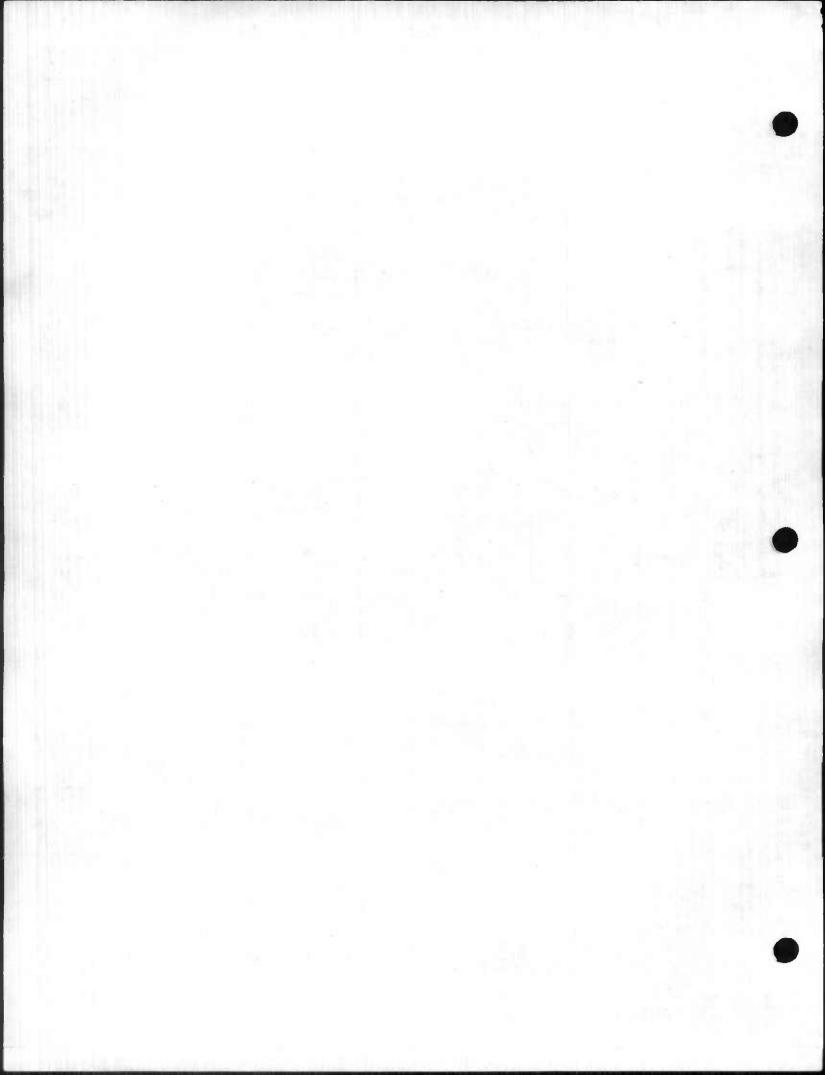


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician ALL 0300 LENDAUGH 2000 ATHERINE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLESV DSNNIE Ann NOEL ANUNDEL ANNE ff Under 24 Hrs. 8. Date of Birth Hours Min. July 20, 1916 If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 300F 84 Yrs. Maryland Director 219.26.4303 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location tOd. Inside City Limits r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 Yes 2 No MD Anne Arundel Director Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 208 Scotts Manor Drive 21061 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours efter 1 Never Married 2 Married 1 Yes XNNo If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: White by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied v Department of Health and Mental Hygie. Important: If itam 27 is marked other th eny injury or other treumatic evant, the page. Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Charles Rollins Emma (Unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 208 Scotts Manor Dr. Glen Burnie, Md 21061 Linda Lacuin/Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 4 Donation 5 ☐ Other (Specify) 8/21 Crownsville, MD 22 Name and Address of Faces, Gary 1. Kaufman Funeral I at Meadowridge Memorial Park 7250 Washington Blvd. Elkridge, MD 21075 Kaufman Funeral Home 21. Signature of Funeral Service Licensee 2600 the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel Lucek disease or condition resulting in death) Examiner be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician a Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco uss contributs to the cause of death? P.O. signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 X No 1 ☐ Yas or Attanding Physicien: effer death. Director: Affer this cartific 25. Was case referred to medicel examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 TYes 2 No 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide e Hospital or 24 hours eff e Funeral Di pietely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I Within 2 To the I 296. Signature and tills a contifier Attending Physician 29c. License number 29d. Date signed (Month, Day, Year) Aug 21st 2000. D44973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GURMEGT - S · SAWHNCSY () 325HOSPITAL DRIVE 202 ylen Burnie MP 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar



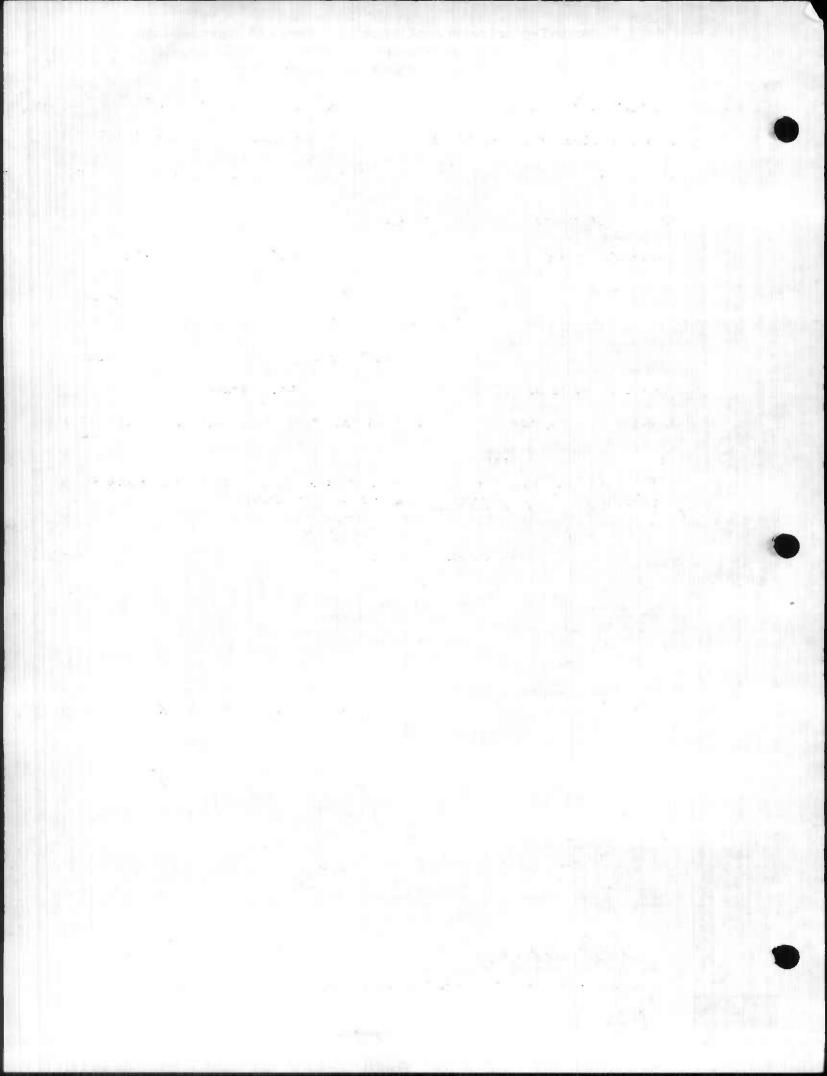
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25587 Certificate of Death Reg. No.

				Clato of It	iaiyiaii				Death	-	Reg. No.	6	6581
	Dhusisian	1. Decedent'a Name	and the same of th							2. Date of De		Year	3. Time of Death
	Physician /Medical	Madelin	e		Alexi	us				August	20 ^{Day} 2000)	8:00 a.m
)	Examiner	4a Facility Neme (If)				4b. City, Town, or				
		Charlesto							Catonsv		Balt		
L	Funeral Director	5. Social Security Nu 723-09-08 Usuel Residence of I	14	M 2 F 7. A	94	last birthday) Yrs.	If Under Months		If Under 24 Hrs Hours Min.		y, Year) 1, 1906	9. Birthp Coun	lace (State or Foreign try)
	land and	1	10b. County		10c. Cit	y, Town or Loc	ation					1	0d. Inside City Limits
	Mary Fresh	MD	Baltimor	`e	Ca	tonsvi	lle						1 ☐ Yes 2 € No
	with the Mar or 28a-fel be notified Director	10e. Street and Num					10f. Zip	Code			10g. Citizen of V	/hat Coun	try?
	hwit 23a c at D	709 Maide	n Choice	Lane			1	2122	8		U.S.	۹.	
020	filed within 72 hours effer death with the Maryland Hygiene. ther then 'natural', or fleme 23a or 28e-f show wit, the Medical Examiner must be notified at a Completed by Funeral Director.	11. Meritel Status 1 Never Merrie 3 Widowed 4	d 2 Merried	12. Wes Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Detes	? (No	- 11	/es Deced Yes, spec		dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Reco Blec Specify	k, White,	
Maryjand 21215-0020	"natural", or		15. Decedent's Edu	cation		16a. Deced	ent's Usua	al Occup	pation		16b. Kind of Bu	siness/Inc	dustry
215	led within 72 ho tygiene. Nor than "natura nt, tre Wedlen Completed	(Specif	y only highest grade	completed) College (1-4or	54)	(Give I life. D	aind of woo	rk done se retire	during most of wo	rking			
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Лаг	2 should and Men is marke	19e. Informent's Nar							and Number or R				Code)
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Baitimore,			Cremetion 3 🗆 🖹	emoval from State	0	lace of Dispos emetery, crem	atory or o	ther pla		Date	20c. Location -		
tim			Other (Specify)	,	Ho.	ly Cros				8//23/0			
Bai	permit. Peges Department of Important: If it any injury or o	21. Signeture of Fun	erel Service Licenia	William	n G. [Dau 22.	Name an	arfo	ecord RD.,	nard J. Baltimor	Ruck Fu e, MD	neral 21214	Home, Inc
		23a. Part1. Enter the shock, or heert	diseese, or complitailure. List only or	cetions that cause ne cause on each	d the death	n. Do not ente	r the mod	le of dyi	ng, such es cardia	c or respiratory a	rrest,		Approximete Intervel Between
	Physician /Medical Examiner	Immediate Cause (F disease or condition resulting in death)	inel a	C	NGES	TIVE	(1e)	ALT	Friw,	CF			2 Mantys
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Вох	eath certi			J			-					-	
	to the death certification of the strength of	Pert II. Other signific	ant conditions con	tributing to death	but not resi	ulting in the un	derlying c	ause gi	ven in Pert I.	23b. Did	tobacco use cor	ntribute to	the cause of death?
P.0	res that the de signed by the a loe detached libe detached liby Physic		^	_						10	Yes 2□ No	3 Proi	bebly 4 Unknown
	be be		ATRIA	- 1-13	2116	ATION							
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of	T di di	1 Yes 2 F	0			ER/Outpatient)A		lome 5 ☐ Resi			y)(y)
	uner uner	27. Manner of Death 1 SNaturel	5 Pending	28a. Dete of In (Month, D	ury ay Year)	28b. Time of Injury		8c. Inju		28d. Describe	how injury occur	ed	
Sio	Attending or deeth. •ctor: After by the fune liffcation	2 Accident 3 Suicide	Investigation 6 Could not be	an Bi 41			М		Yes 2□No	204 Lauretian (Owner and North	D.	- Doub Alimber
Division	tal or Attending P rs efter deeth. el Director: After t ied in by the funer: Certification:	4 Homicide	determined	28e. Plece of In building, e	itc. (Specify		et, rectory	у, опісе		City or To		er or mura	al Route Number,
	Hospi 24 hou Funer stely fill	29e. Certifier (Check only one)	Certifying Phys	elcian: To the besider: On the besider	of examine	wledge, death tion end/or inv	occurred estigation	et the ti	me, date and place opinion, death occ	e, and due to the urred et the time,	cause(s) and ma date end place,	nner es s	lated.) the cause(s)
	within X	29b. Signeture and ti	tle of certitier	/			290	c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
	- > - 0	> N	21	16	-			DI	1474	0	A	- 7	1 2000
		30. Neme end addres	s of person who co	mpleted cause of	death (Item	23a) (Type I	Print)	V.	77/7				1,2000
	(10)	MATTHE	,	ANZETT			OFN	011	SICE LA	N.E. C.		, -	40
	State	31. Date tiled (Month	Day, Year)		rar's Signa			- 17	JICE LA	NE C	TONIUC	1	
	Registrar	AUG 2 3	2000	neus	1 6	1 11	20 60						

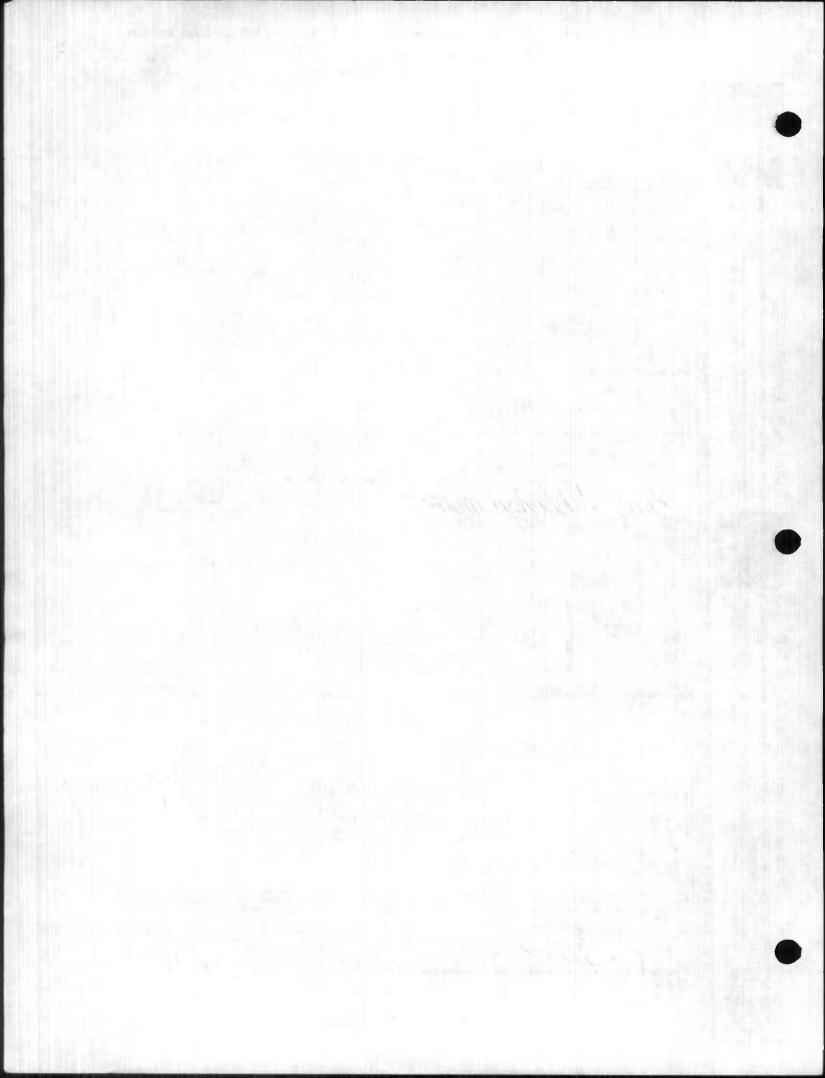


State of Maryland / Department of Health and Mental Hygiene 00 26588

					Cer	tificat	e of	Death		R	eg. No.	bus	0000	
		1. Decedent'a Name (First, Middle	, Last)	M. F. J.						2. Dete of Deat		Veer	3. Time of De	
Physici '/Medic		WALTER B. BA	KER JR.							August	8, 200	0,000	4:30 P	M
Examir		4a Facility Name (If not institution FRANKLIN SQUAR						ROSE		ocation of Deeth	4c. County BALT	of Death		
Funeral Director		5. Social Security Number 219-01-4691 Usual Residence of Decedent	6. Sex 1 X M 2□ F	Age (In yrs. last 81	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, June 23		9. Birthp Coun	MD	oreigr
pue * =		10a. State 10b. County		10c. City, T	own or Lo	cation	-					1	0d. Inside City L	imits
be Mary	Director	MD Balti	more]]	Balti	7							1 □ Yes 25	₹ No
th with the		10e. Street and Number 8820 Walther Bl	vd #1601			10f. Zip	Code	21:	234	1	0g. Citizen of V U	What Cour SA	htry?	
d within 72 hours after deeth with the Manyland delen. The manyland glens. The Moderal Exameter must be notilied at	by Funeral	11. Marital Status 1 Never Merried 2 Marri 3 Widowed 4 Divorced	12. Was Deceder Armed Force ed 1X Yes 2[If Yes, Give Yeer or Dates	s? ∃No		Wes Deced f Yes, spe- 1 ☐ Yes		lispanic Origan, Mexican Specify:	gin? (Spe n, Puerto	ecity Yes or No- Rican, etc.)		ck, White,	ean Indian, etc.	
72 hours	Completed	15. Decedent (Specify only highes	's Education		6a. Deced	kind of wo	rk done	during most	t of work	ina	16b. Kind of Bu	usiness/Ind	dustry	
within iena. than	nple	Elementery/Secondary (0-12)	College (1-40	r 5+)	life. L	OO NOT u	se retire	1)						
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Mentel Mentel arked o	TOE	Walter B. Bak	er Sr					На	azel	Tress				
2 should and Mer is mark		19a. Informent's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address	(Street	and Numbe	er or Rura	al Route Number	City or Town,	State, Zip	Code)	
	ы	Dorothea Baker	/spouse		8820	Walt	her	B1vd	#160	01 Balt	imore,	MD	21234	
8077		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp		0.000	e of Dispo- etery, cren	sition (Name	ne of other pla	ce)	1	Date	20c. Location -	City or To	own, State	
Physician /Medical Examiner	Examiner	21. Sign and of Europea Service Control of the Cont	complications that cause only one cause on each	ardial Due to (or es	Ba Do not ente Infar s a conseq	altim er the mod cctio quence of):	ore, le of dyi	MD	2120			more	Approximete interval Betwee Onset and Dea 2 days	en ith
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elcian: The	Be	25. Was case referred to medical						26. Plece	of Deat	h (Check only or	10)	1		
Physician: this certific ral director,	10	examiner?	Hospitel: 1 Nnpa	itient 2 ER	/Outpatien	t 3 D	DA Ott	ner: 4 Nu	ırsing Ho	me 5 Reside	enca 8 🗆 Oth	ner (Specil	(y)	
ttending death. ctor: Affer y the fune	Certification:	27. Menner of Death 1 Neturel 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide	etion of be 28e. Piece of	Dey Year) Injury - At home etc. (Specify)	b. Time of Injury o, farm, str	М		yat k? Yes 2□	No	28f. Location (Si City or Town	treet and Numb		al Route Number	r,
Hospital or A 24 hours after Funeral Directely filled in b	edical Cer	29a. Certifier 15 Certifyin (Check only 2 Medical	g Physician: To the bes	st of my knowle						and due to the c	euse(s) end m			
To the To the Complet	Med	one)	end menner	stated.		20	n Liner	e number		0	9d. Date signe	rd (Manth	Day Year	
0 1 ki 7	-	29b. Signature and title of cartifier	1.1.	1		29			6	2	V lo	/ (Month)	Day, 1 oai)	
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W	0	30. Name and address of person of Dr. Stuart Ack		Frankl			Dr	Ro1	time	ore MD	21237			
Sta	te	31. Date filed (Month, Dey, Year)		strar's Signature		quare	DI.	Dal	CTIIIC	JE S III	21231			
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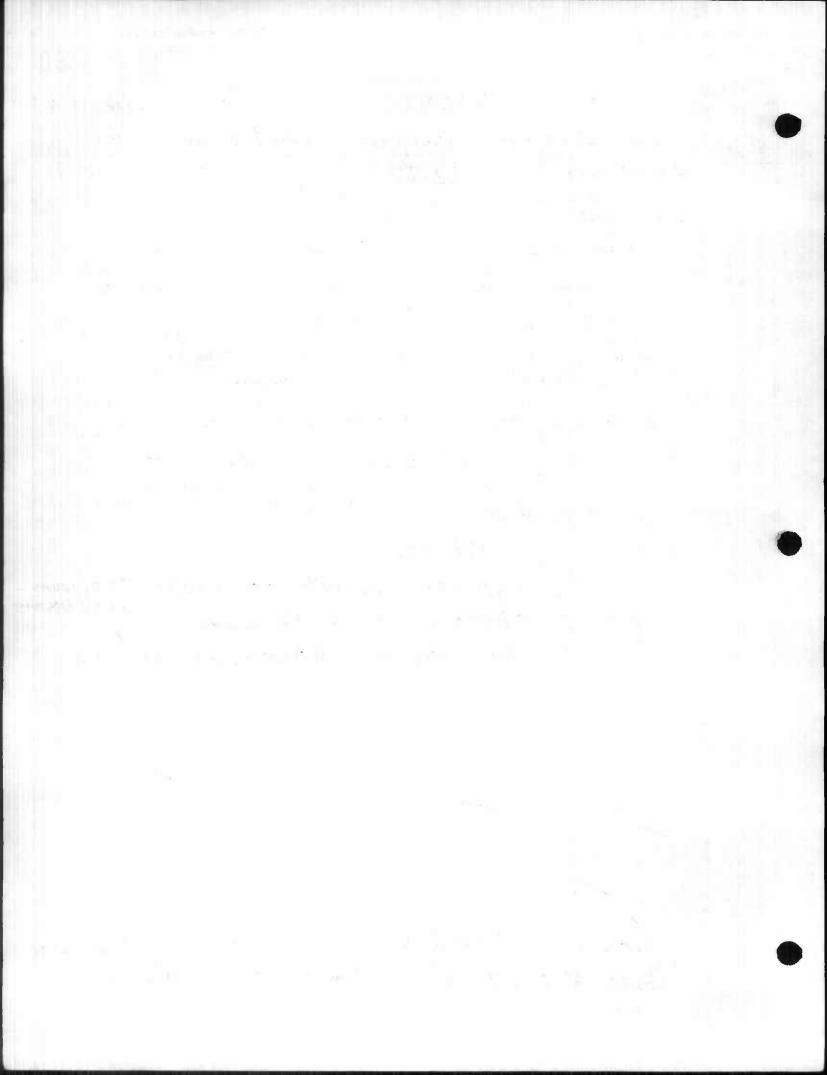


	1. Decedent's Na	ame (First, Middle, L										
Obviolation	- /		.ast)			,			2. Date of D	Death / Dev	Year	3. Time of Death
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Examiner		a (If not institution, gi	ive street end	number)	1.1		1	4b. City, Town,	or Location of De		ty of Death	
Examiner	. 1 -	1 01.	anyla	11 1.	//	Cur.	Louis	Balti	4000 0			
	5. Social Security		Sex		In yrs. lest bii	mhus	If Under 1 Yea	r If Under 24 H		Bal	timor	
uneral			1 M 2 W	F	11 yrs. 1031 Dil	Yrs.	Months Deys		in. 8. Date of E	Day, Year)	Cou	nplace (State or Foruntry)
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ot Be	MD.	Balto.		Ca	tonsv	ille						-X
or thems 23e or 28e-fahow maner mant be notified at / Funeral Director	10e. Street and f	Number					10f. Zip Code			10g. Citizen o	f What Cou	untry?
23a	3 Ginfor	d Place U	Init 20	1			21228			USA		
thems 23	11. Marital Statu		12. Was C	Decedent Eve	er in U,S.	13. W	as Decedent of	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or I	No- 14. Ri		ican Indian,
E B E		erried 2 Married	1 TY	Forces?					eno moan, etc.)		lack, White	
by by	3 🕽 (Widowed	d 4 Divorced	If Yes, Year o	Give A Dates:		11	☐Yes 25 No	Specify:		Spec	TIHW ^{dis}	re .
		15. Decedent's E	Education		16a	. Decede	nt's Usual Occi	upation		16b. Kind of	Business/l	ndustry
Se 85		pecify only highest g				(Give ki	ind of work don O NOT use retir	e during most of v ed)	vorking			
marked other than "naturimatic avent, the Medical To Be Completed	Elementary/Se	econdary (0-12)	Colleg	e (1-4or 5+)						-		
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<u>= 3</u>	19a. informant's	Name/Relationship	(Type, Print)		198	o. Mailing	Address (Stree	et end Number or	Rural Route Nurr	nber, City or Tow	ın, State, Z	(ip Code)
127 er tr	James I	Santee			19	140	Shadowo	od Dr Mo	nument	. Co. 80	132	
item 27 other tr	20a. Method of D	Disposition			20b. Place o	T Disposi	ition (Name of etory or other of	od Dr. Mo	Date	20c. Location	n - City or T	Town, State
7 04		2 ☐ Cremation 3 I n 5 ☐ Other (Spec		om State							ar C-	rings, M
Important: any injury 2008.		Funeral Service Lice			TOPIA.		Name end Add		0/24/200	o ropi	ar sp	I Tugs, M
Important: If it any injury or o	NI	1 1	1.0						T			
	ny	R DC	Vang	U M	0120	163	O'Edmon	eral Hom dson Ave	es, Cator	sville,	Md.	21228
	23a. Pagh. Ente	er the disease, or cor- eart failure. List only	mplications in	at caused the	e death. Do	not enter	the mode of dy	ving, such as card	lier or reeniretory	arrest		Approximate
sician								, 9, 000 00 00	nac or respiratory	u., 001,		Interval Between
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State of Maryland / Department of Health and Mental Hygiene 00 26

		Cei	rtificate of Death	Re	ig. No.	U
Physician	Decedent's Name (First, Middle, Last)	Dinne	(4) 10	2. Date of Death Month	Day Year	Death
/Medicai	MILDRED	BARNE		8	20 2000 1 4	414
72 hours after deeth with the Maryland Construction of the Constru	4a. Facility Name (If not institution, give street and response to the street of the s					Foreign
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d Inside City	a B innian
	Md. N/A				10d. Inside City	
be notified Director	10e. Street and Number		BALTIMORE			
	1632 BALMOR COURT		10f. Zip Code 21217		0g. Citizen of What Country? U.S.A.	
ral', or items 234 Examiner must	Armed	Forces?	Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexicen, Pue 1□ Yes 2□ No Specify:	Specify Yas or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. AFRO - AMERICAN Specify:	N
natu	15. Decadent's Education (Specify only highest grade completed	(Give	dent's Usual Occupation kind of work done during most of we	orking	6b. Kind of Business/Industry	
t, me Medical		(1-4or 5+) FOO	DO NOT use retired)		ALTIMORE CITY I EDUCATION	DEP
27 is marked other or raumatic avent.	17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) GFORGEANNA JOHNSON					
	19a. Informant's Name/Relationship (Type, Print) 19b.		9b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)			
	BERTILLA DAVIS -NIECE		2623 MURA ST. BALTO. MD		. 21213	
nt: If flem	20a. Method of Disposition Surial 2 Cremation 3 Removat from 4 Donation 5 Other (Specify)	n State	netory or other piece)		Oc. Location - City or Town, State	
Departmen Important: any injury once.	4 Donation 5 Other (Specify) MT. ZION CEM. AUG. 26, 2000 BALTO, MD.					
	CALVIN B.SCRÚGGS FUNERAL HOME					
	23a. Pairt. Enter the disease, or complication that shock, or heart feilure. List only one cause of	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	412 E. PRESTOR	N STREET	BALTO, MD. 212	
he attending physician and ed for use as the burtal-transit and sicial and edical Examiner	that Initiated events resulting in death) Last	Due to (or as a consect of PER TENS) Due to (or as a consect of PER TENS) Due to (or as a consect of PER TENS) ERI PHE RE	quence of): (VE ARTERIO quence of): 2ENAL FAI quenca of):		OTIC CARDIOU CHLARDI DISFASE	SE
the at the street for	Part tt. Other eignificant conditions contributing to	death but not resulting in the u	in the underlying cause given in Part I. 23b. Di		lid tobacco use contribute to the cause of death	
ed by the detached			10		Yes 2 No 3 Probably 4 Onknow	
2 should be pleted by			24a. W		a autopsy led? 24b. Were autopsy fin available prior to completion of car of death?	
his certific il director. To Be				1 □ Ye	s 2 No 1 Yes 2 N	40
	25. Was case referred to medical exeminer?		Other	eath (Check only one		-
	1 195 2 NO 1 1	inpatient 2 ER/Outpatier	item		g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
	1 ☐ Natural 5 ☐ Pending (Mo	nth, Day Year) Injury				
al Director: After the din by the funeral control of the funeral con	2 Culoido 6 Could not be				Location (Street and Number or Rural Route Number, City or Town, Stete)	
Within 24 hours energy To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.					
	29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year)					
	30. Name-and eddress of person-who completed cause of death (Item 23a) (Type, Print) RON SECOURS HOSPITAL					000
	30. Name and eddress of person who completed ca	Z M.J.	Print) BOY SEC	ours i	HOSPITAL	
State	31. Dete filed (Month, Day, Year) 32/	Registrar's Signature	Sparks			



BYRGHAYSER

BURGHAUSER

Physician/Medical by Completed Be 2

29a. Certifier

29b. Signeture end title of certifier

nding physician end use es the burial-transit Division of Vital Records, P.O. Box 68760, been signed by the eshould be detached certificate After this Certification: To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu death. edical

MARIAL

1. Decedent's Neme (First, Middle, Last)

Physician

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.

25. Wes case referred to medical Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25€No

28e. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 1 Netural 2 Accident 5 Pending Investigation 3 Sulcide

6 Could not be 4 Homicide

28b. Time of

28e. Pleca of fnjury - At home, farm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Plece of Deeth (Check only one)

29c. License number

28c. Injury et Work?

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29d. Dete signed (Month, Dey, Year)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

1 Yes 210No

24a. Wes en eutopsy performed?

Other: 4 Nursing Home 5 Tesidenca 6 Other (Specify)

26591

Birthplece (State or Foreign Country)

Balto County, MD

White

10d. fnside City Limits

21087 Approximete Interval Between Onset and Deeth

4 years

3 Probably 4 Unknown

24b. Were eutopsy findings eveileble prior to completion of cause of death?

1 Yes 2 No

1 Yes 2 No

3. Time of Death

7:50 Am

Reg. No.

2. Dete of Death

Month

Aug

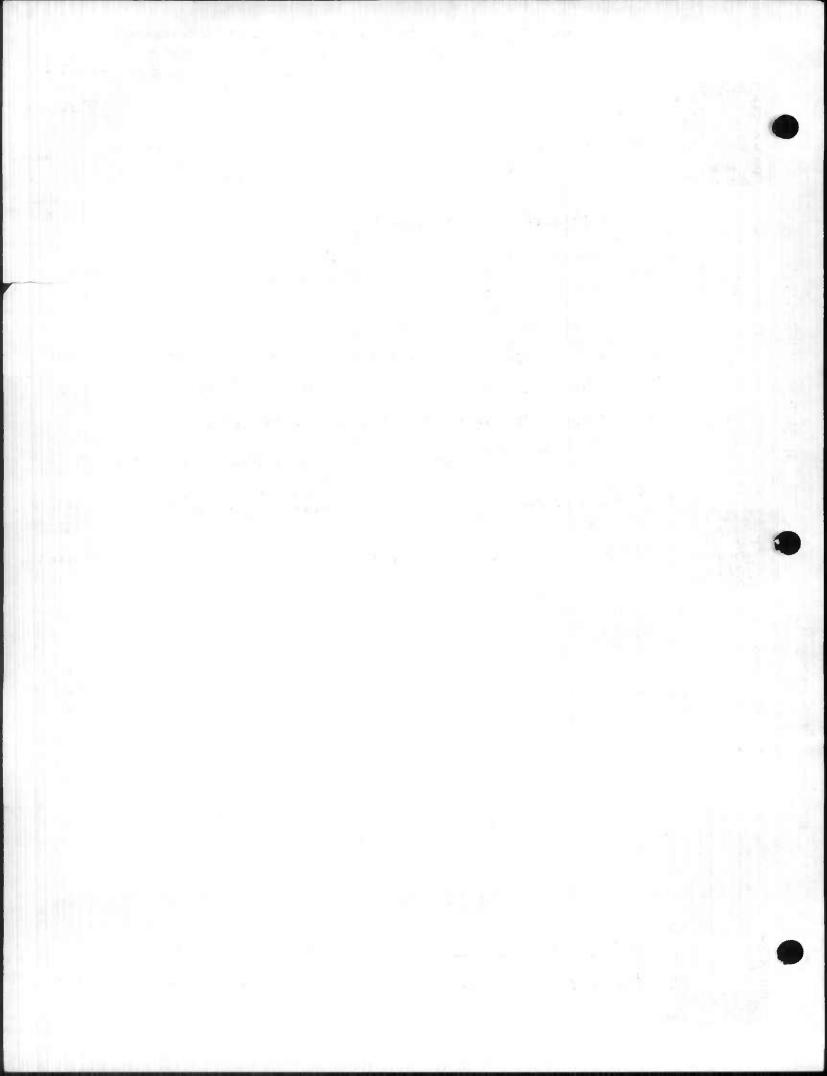
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Michael , mi) Ilum

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture AUG 2 3 2000

9105 Franklin Square Drive

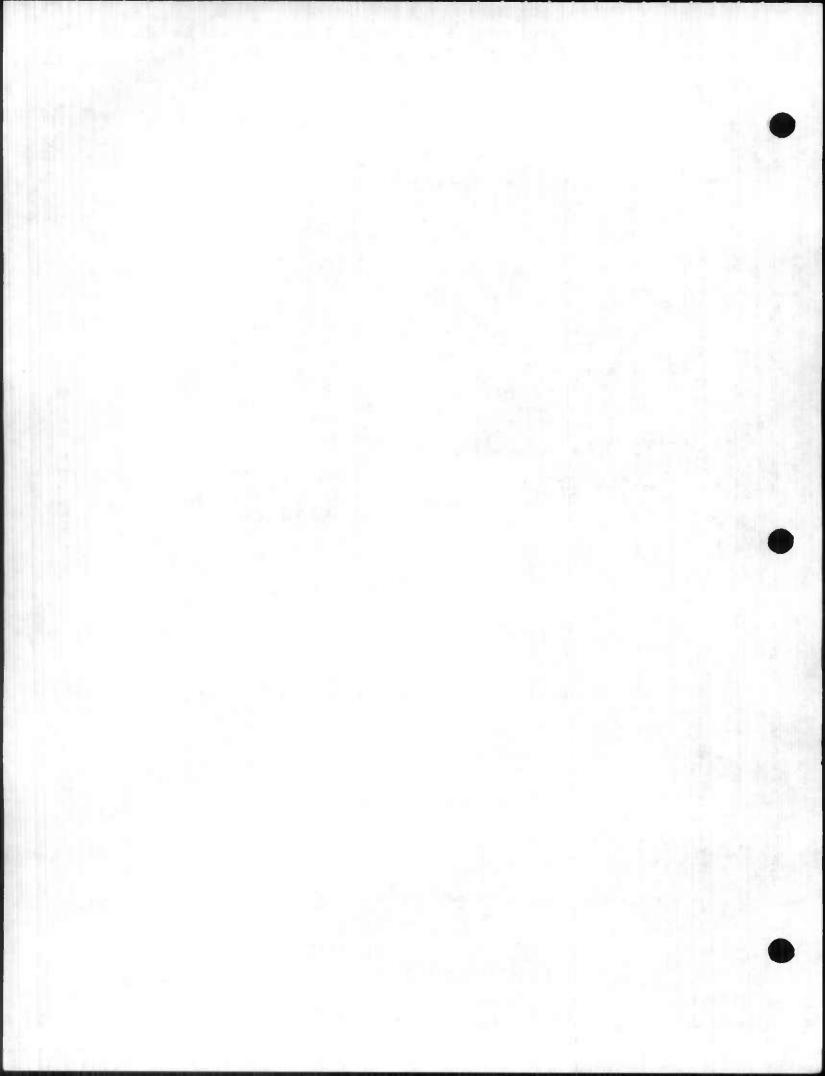
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 26592

			Ce	ertificate	e of Death		Reg. No.						
ysician	1. Decedent's Name (First, Middle, Las		D. 141.			2. Date of D	eeth Day	Year 3. Time of Death					
ysiciaii Medical		Mary Bou	rne Baith	IS		augu	st 18 %	2000 3.650					
aminer	4e Facility Name (If not institution, give	and the second			4b. City, Tow	n, or Location of Dea	th 4c. County						
	St. Elizabeth 5. Social Security Number 6. S	Rehabilitation 8	Nursing Hor		1 Yeer If Under 2	Baltimore	eth.	Baltimore City					
eral ctor		ox 7. Age (80 Yrs.	Months	Days Hours	Min. (Month, D	ay, Year) 1, 1920	Birthplace (State or Fore Country) VA					
**	10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Lim					
fled	Maryland H	oward			Ellicott Cit	ty		1 ☐ Yes 2 ☑ N					
Il Directo	10e. Street and Number 3006 Center Drive			10f. Zip	Code 210	42	10g. Citizen of V	Vhat Country? U.S.A.					
by Funeral	11. Meritel Sfetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:	er in U,S. 13.	Was Deced If Yes, spec		in? (Specify Yes or N Puerto Ricen, etc.)	o- 14. Rac Blac Specify	e - American Indian, sk, White, etc.					
pete	15. Decedent's Ed (Specify only highest gra	ucetion de completed)	16e. Dec	edent's Usua e kind of wor	Il Occupation rk done during most (se retired)	of working	16b. Kind of Br	usiness/industry					
Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	1.00			Home					
	17. Fether's Name (First, Middle, Last)	1+			Homemake	's Name (First, Middle	Maidan Suman	nol .					
Be		cott Miller, Jr.			10. Mother		abeth Lee S						
2	19a. Informant's Name/Reletionship (1		10h Mai	lina Address	/Street and Number	or Rural Route Numi							
		id Balthis	130, 19141	-	*	cott City, Maryl		01010, 219 0000)					
	20a. Melhod of Disposition 1 □ 18urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific		20b. Plece of Disp cemetery, cri	ematory or o	ther place)	Date 09/07/00		City or Town, State					
A A A	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the dialese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the large of the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, interval Between the such as cerdiac or respiratory arrest, in the such as cerdiac or respiratory arrest, in the such as cerdiac or respiratory arrest, in the such as cerdiac or respiratory arrest.												
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Couse (Disease or Injury that initiated events resulting in death) Last	b. <i>END</i> \$ 7	DISCASE										
clan/Me		d											
/ Physician/	Part II. Other significant conditions co	ontributing to death but	not resulting in the	underlying c	euse given in Part I.	23b. Dic	tobacco use co	ntribute to the cause of dea					
y Phy						1	Yes 21 No	3 Probably 4 Unkn					
Completed by						24e. We	s an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of death?					
Сотр						1□	Yes 2 No	1 ☐ Yes 2 ☐ No					
Be C	25. Was case referred to medical				26. Piace	of Deeth (Check only	one)						
5 .0	exeminer? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Outpatio	ent 3 DC	Other: 4 Nur	sing Home 5 Res	sidence 6 Oth	er (Specify)					
funera fon:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		(ear) 28b. Time fnjury	of 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ N		how Injury occur	red					
Certification:	3 Suicide 6 Could not be determined	28e. Plece of fnjun building, etc.	r - At home, ferm, s (Specify)	freet, factory	/, office		(Street and Numb own, State)	per or Rural Route Number,					
edical		yalclan: To the best of iner: On the basia of e and manner stete	kamination and/or I					enner as stated. and due to the cause(s)					
	and manner steted. 29c. License number 29d. Date signed (Month, Day, Year)												
	DIGGIA August 18,												
000	30. Name and eddress of person who		th /Item 23a) /Time			BALTIMORE							



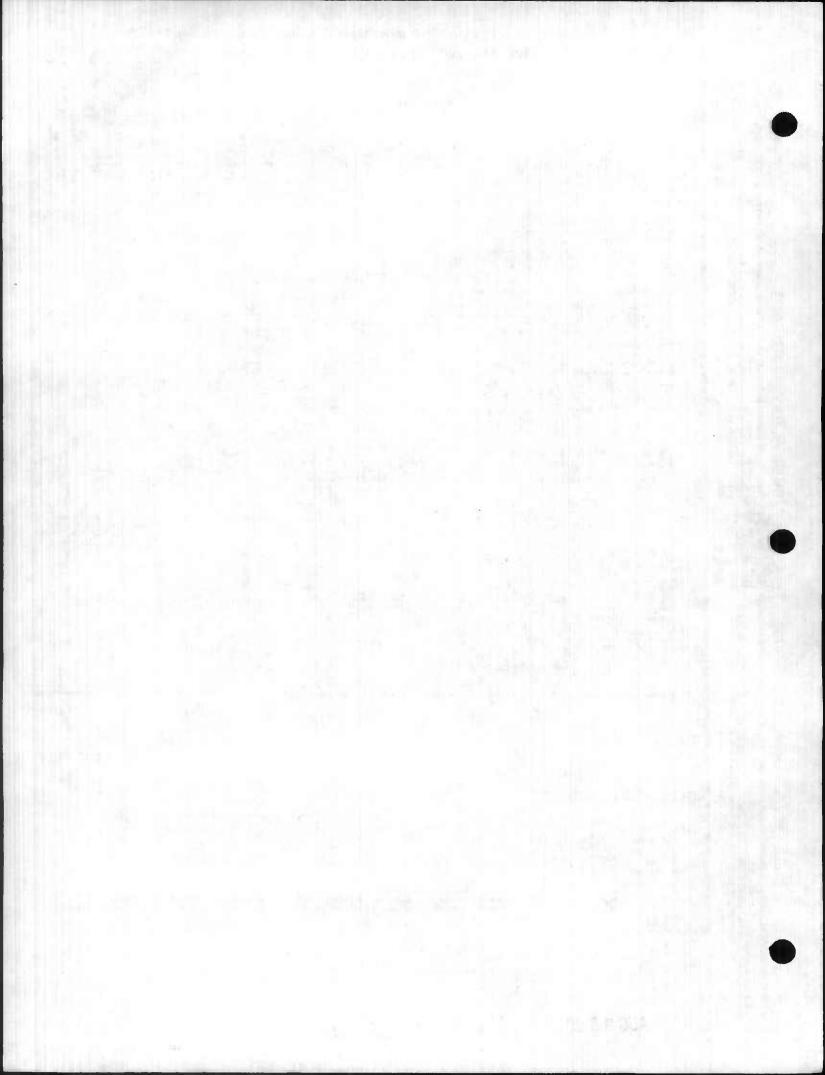
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State of Maryland / Department of Health and Mental Hygiene 0.0. 2.5.5.9.3

			Certificate of Death		ierie U (2	5593
				2. Data of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		DELLA MARIE BUCKS	AUGUST	19, 2	000	11:30 PM
	Examin	_	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death	4c. County		- 0 - 0
			HERITAGE GENESIS ELDERCARE NIA		-	Tim	
	Funeral Director		5. Social Security Number 2/9-26-2176 6. Sex 1 Months Days Hours Min. Usual Residence of Decedent	8. Data of Birth (Month, Day, DEC 10,	Year) 1918	9. Birthpla Country WES7	v I RG IN/
	Par II		10a. State 10b. County 10c. City, Town or Location			100	d. Inside City Limits
	the Mary	Director	MD. HARFORD BEL AIR				1 Yas 2 No
	h with the 23s or 2 and 25s or 2	al Dire	106. Street and Number 101. Zip Code 2 1014	11	Og. Citizen of V	Vhet Countr	y?
5-0020	urs after dea al', or flams Examiner m	by Funer	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Nevar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No 11 ☐ Yas 2 ☑ No	cify Yas or No- Rican, etc.)	Blac	e - Amarica ek, White, et : WH	lc.
215-0	hin 72 ho in "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ng	16b. Kind of Bu		
21	of the	Com	6th HOMEMAKER		OWN		OME
pu	digital distribution of the state of the sta	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name SADIE 18. Mother's Name		Maiden Surnam		
yla	Merita Marka Marka Marka	10	000011	- 10			2.43
Ma	Dan Than	7	19a. Informant's Name/Relationship (Type, Print) 9 and 19b. Mailing Address (Street and Number or Rural SUSANNA HARRIS / daughter 119 WILLIAMS ST				
6	Heat Mm Z		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -		
timo	ment of tant: If it jury or a		4□Donation 5□Other (Specify) GALVENS OF FAITH		BALT		
Bal	Departiment important in portant		21. Signature of Funeral Service Licansee 22. Name and Addrass of Facility Connectly fonera 7/10 50/1/655 Por	AL HOM	E OF	Dun D.	ALK ND 21222
5	Physician		23a. Part 1. Enter the disease of complications that caused the death. Do not anter the mode of dying, such as cardiac or shock, or heart failure.	r raspiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. COROMARY ARTERY DI	SEAS	E		
		er	Due to (or as a consequence of):			1	
	d d ansit	Examiner	Sequentially list conditions. b. DIABETES MELLITUS Due to (or as a consequence of):			1	
o,	icate be executed physician and s the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury				
68760,	physicies the bu	dicai	Cause (Disease or Injury that initiated events raeulting in death) Last Due to (or as a consequence of):		1		
	ding ding se a	-	AMEMIA			1	
. Box	death cer e attendin ed for use	siciar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
P.0	ed by the detached	by Physician/M		1 🗆 Y	es 2 No	3 ☐ Prob	ably 45 Unknown
Records,	law requires that as been signed 2 should be det	Completed b		24a. Was a perform		avai	re autopsy findings llable prior to apletion of cause eath?
Ä	0 - 0	E O		1 O Ye	s 2 No	10	Yes 25 No
Vital	certificate rector, pag	Be	25. Was case referred to medical 26. Place of Death examiner?	(Check only on	10)		
of V	Physician: this certific ral director,	2	1 ☐ Yea 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 450 Nursing Hon				
ou c	Affect Affect funera	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe ho	ow injury occur	red	
Division	Attending or death. ector: After by the fune	ficat	3 Suicide 6 Could not be	28f. Location (Si	reet and Numb	per or Rural	Route Number,
Div	after Dire	erti	4 Homicide determined building, etc. (Specify)	City or Town	n, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai C	29a. Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred and manner stated.				
	o the	Me	29b. Signature and title of certifiar 29c. License number	2	9d. Date aigne	d (Month, D	Day, Year)
	- S + S				8191	100	
	()		30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Sarjuder K Tulle 2 Martled Place Bo		- 100	10	
			Sarjuder h Talle 2 Market - Vlace Be	itti ne	e MI) 21.	222
	Sta		31. Data filed (Month, Day, Year) 32. Registrar'a Signature				
	Registr	ar	AUG 2 3 2000 B				

DHMH 16 Rev 6/95

ORIGINAL



DHMH 16 Rev 6/95

To the Hospital within 24 hours a To the Funeral Completaly filled

State Registrar

Medical

29e. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 2 2 2000

DAVID E. BOERSMA, M.D., 760; 3. Registra Signatur

30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print)

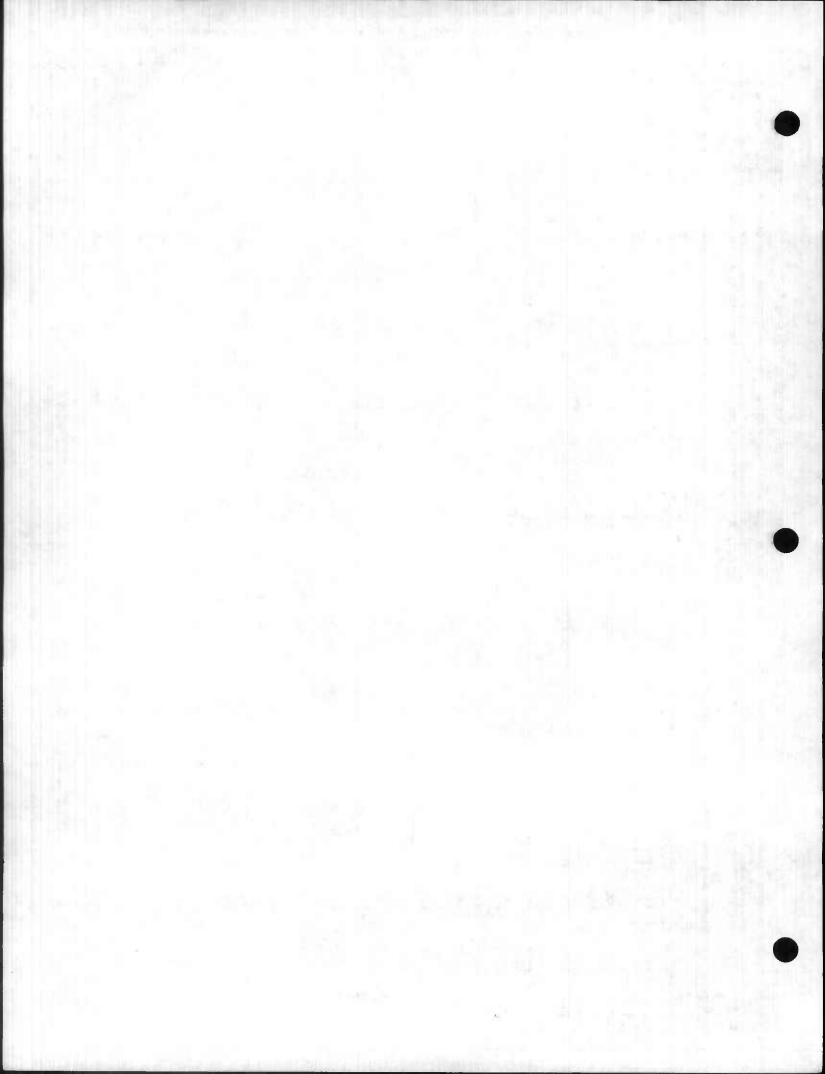
15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number D 40048

OSLER DRIVE, TOWSON, MARYLAND, 21204

29d. Date signed (Month, Day, Year)

8-21-00



00-4098-0						
B.K.S	Please Type or Print in I	Black Indelibie Inl	k. Assure A	II Coples A	Are Legible.	
MAJORIE S	UE CAMPBELL State of Marylar n#22 per FH G786 8-24-00 WJJ	nd / Department of Certificate or			0.0	26595
Michaed Itea	Decedent's Name (First, Middle, Last)	Oertinicate of	Dodin	2. Dete of Death		3. Time of Death
Physician /Medical	MARJORIE SUE CAMPBELL			Month JULY	24, 2000	1713 PM
Examiner	4a Facility Neme (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	4c. County of Deat	h
	4307 CEDAR LANE	THE WALL	MT.AIRY		CARROLL	

If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Min. 1□M 20 F Months Hours UNK Director 42 Sept Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location "natural", or items 23a or 28a-f show MD Mount Airy Carroll Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the M. Dopertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or here 23a or 28a-4 any Injury or other traumatic event, the Medical Examinar must be hollife. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 4307 Cedar Lane USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Stetus unk Bleck, White, etc 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 22. Name end Address of Fecility State Anatomy Board 655 W. Baltimore 21. Signeture of Fune al Service Licenses Street Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heert failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificete be executed been signed by the attending physician and should be detached for use as the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as e consequenca of): algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Yes 2□ No 3□ Probably 4□ Unknown Division of Vital Records, þ 24a. Was an autopsy performed? page 2 should Completed certificate has Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE Medical Certification: To 17 Yes 2 No 3 DOA within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the luneral dir 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29b. Sig O.C.M.E

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 29d. Dete signed (Month, Day, Year) JULY 25, 2000 and address of person who completed cause of deeth (Hem 23e) (Type, Print)

After 111 Penn Street, Baltimore, Maryland 21201

iled (Marylay, 2es) 2000 32. Register Signature

Birthplace (State or Foreign Country)

white

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of deeth?

Yes 2 No

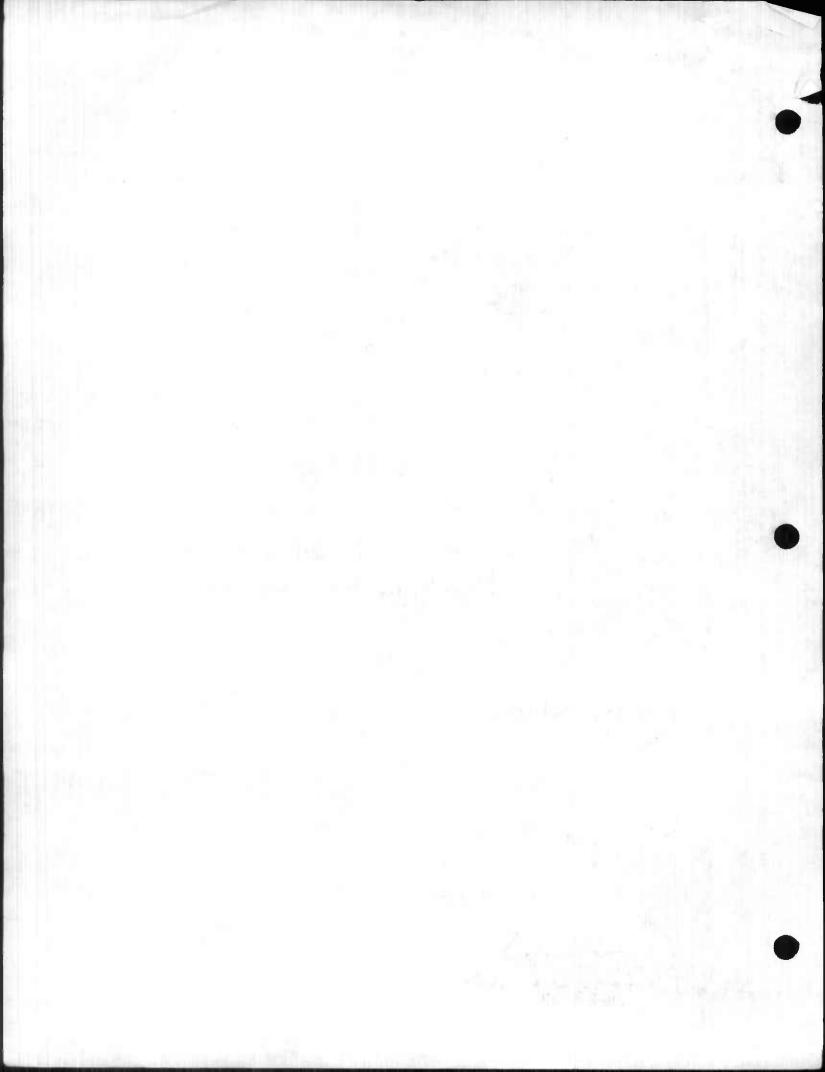
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10d. Inside City Limits

1 Yes 2 No

State

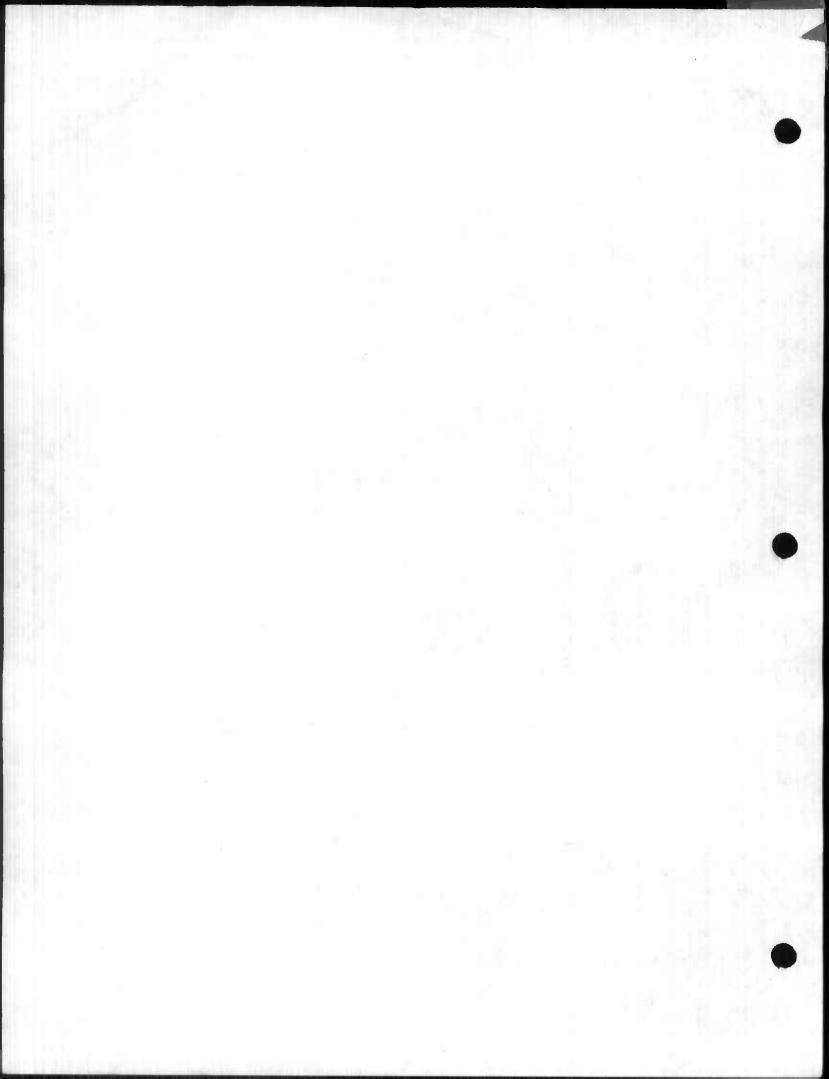
31. Date filed (Month) By 200



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State of Maryland / Department of Health and Mental Hygiene

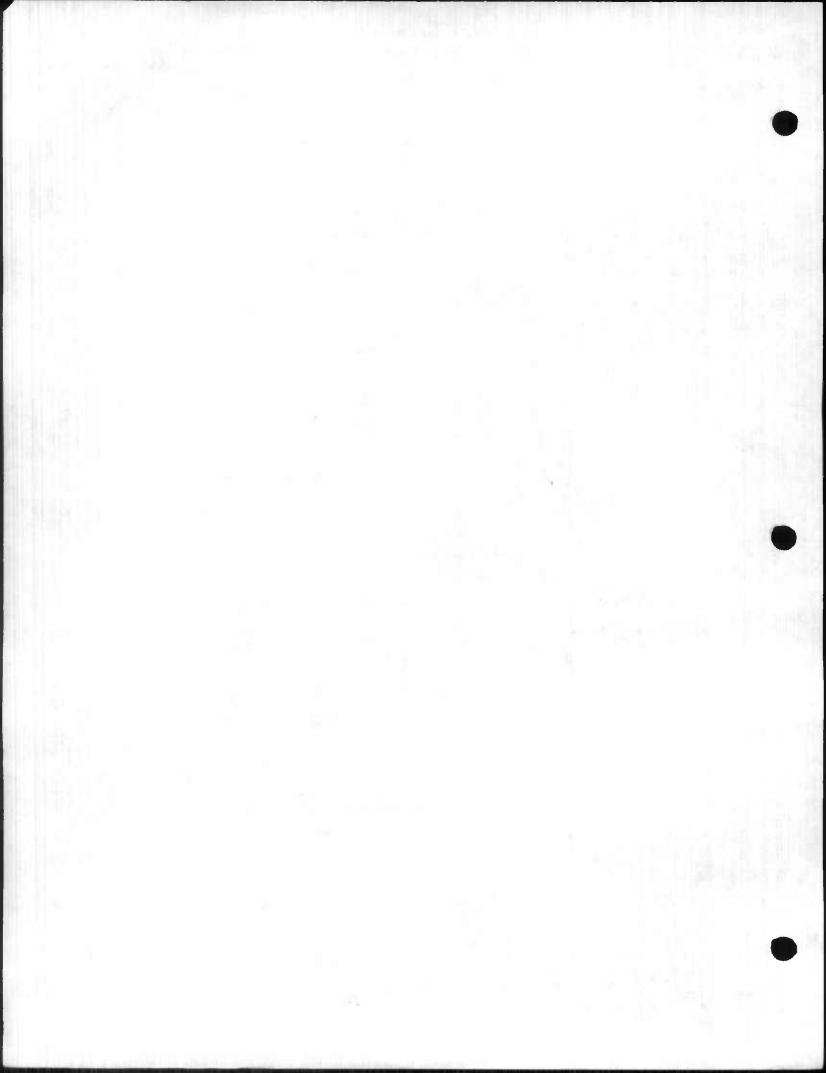
						Cer	tificate	e of	Death			Reg. No.	JU	26596	
		1. Decedent's Name	(First, Middle, L	ast)							2. Data of De		Vana	3. Tima of Death	
Physicia	-	JAMES CI	ROWDEN								Month July	Day 23	2000	5:44 P.M	
/Medica Examine	_	4a Facility Nama (# r	not institution, g	iva street and nu	ımber)			- 4	b. City, To	wn, or Lo	cation of Death			10.44 1.11	•
LAdilling	1	Johns Ho	onkins H	lospital					Ra	ltimo	ore		N/A		
Funeral		5. Social Security Nur	-	Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under	24 Hrs.	8 Date of Bir	th	9. Birth	placa (State or Foreig	חק
Director		unk		1∰M 2□F	48	Yrs.	Months	Days	Hours	Min.	Oct 31	, 1951	Coui	unk	
70		Usuat Rasidence of D	ecedant						1						
How M		770017110	10b. County	27 / 4	10c. City	, Town or Loc							1	10d. Insida City Limit	
M 7 M	oto	MD		N/A			Balti	mor	е					1 Yas 2 □ No)
with the Marylar a or 28s-f show Libe notified at	Director	10e. Street and Numb	ber				10f. Zip	Coda		-1,3		10g. Citizan of	What Cour	ntry?	
h will		221 Fren	nont Av	enue			The I			2120	1	U	SA		
er death with the Maryla Rems 23a or 28a-f show ther must be notified at	Funeral	11. Marital Status	unk	12. Was Dec	edant Evar in U,	S. 13. W	Vas Deced	ant of H	ispanic Or	igin? (Sp	ecify Yas or No Rican, etc.)	- 14. Ra		can Indian,	
2 2 E C		1 Never Married	d 2 Married	1 Yas	2 No				Specify:		rican, etc.)		ck, Whita,		
5 5	ρ	3 Widowed 4	Divorced	If Yas, G Year or D	Dates: unk		LI Yas 2	AND INO	Specify.			Specil	y: D1	lack	
12 ho	Completed		5. Decedent's I			16a. Deced	ent's Usua	Occup	ation during mos	et of work	ina	16b. Kind of B	iusinass/in	dustry	
Na sa	ple	Elementary/Second		rada completed) Collaga (1-4or 5+)	lifa. D	O NOT us	a ratired	d)	or work	ang.				
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the state of		19a. Informant's Nam		(Type, Print)			-					er, City or Town		Code)	
and and a		O.C.M.E	•			111	Penn	Str	eet	Balt	imore,	MD 212	01		
- 25 mg		20a. Mathod of Dispo		□D	06	ace of Dispos ematary, cram	sition (Nam	ne of ther place	ce)		Data	20c. Location	- City or To	own, State	
Page nent of mrt: If		1 Burial 2 4 Donation 5	KlOthar (Spec	in s											
Series and a serie	1	21. Signature of Euro	eral Service Lice	engege a	Dianahan	22.	Name and	d Addra	ss of Facili	ty	1 (55		1		
0 88188		X Innu	ell g	MY Viso	Director							W. Balt	lmore	e Street	
	-	23a. Parti. Enlar tha shock, or heart	disaase, or co	mplications that	causad the death	. Do not anta	r the mode	a of dyir	, MD	cardiac	O1 or raspiratory a	rrest,		Approximata	
Physician		shock, or heart	failure. List on	y ona causa on	each lina.									Onset and Death	
/Medical		Immediata Cause (Fi	inal					- 1			1				
Examiner		disaasa or condition resulting in death)		a/	Dua to (or	91	unsn	OT	W	une	15		1		
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betu de	Examiner	0		b	Due to (or	as a consequ	usace of):	_					-		_
oxec exec	EX	Sequentially list cond if any, leading to imm cause. Enter Undarly Cause (Disease or in	nediate		Dua to (or	83 8 CO1130Q1	dance or,								
oertificate be executed ding physician and use as the burial-transit	edicai	that initiated events		c	Dua to (or	as a consequ	iance of):								_
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Seath certification of for use as 1	2			d											-
death death	Physician	Part II. Other signific	ant conditions	contributing to d	leath but not resu	iting in the un	nderiving c	ausa div	an in Part	L	23b. Did	tobacco use co	ontributa f	to the cause of deati	1?
e de de	Ž.										10	Yaa 20 No	3 □ Pro	bably 4 Unknow	wn
s tha	Dy P														
w requires that the death cert been signed by the attendin should be detached for use	8										24a. Was	an autopsy	24b. W	/ara autopsy findings	
3 8 8 8) jet										репо) med /	C	ompletion of cause f death?	
The law ste hes b	Completed										101	Yes 2□No		and a	
VICAL TO INCIDENT THE IAV		25. Was casa raferre	d to modical						00.51	10	1,20			Yas 2 No	
Physician: The lav	ne C	axaminar?		Hospital:	1	ED/O-1	• • • • • • • • • • • • • • • • • • •	Ott	oor:		h (Check only		h /0	74.A	_
Physical Series	0	1 XYes 2 Ne 27. Mannar of Death	0			ER/Outpatient 28b. Tima of		A	4UN	ursing Ho		dance 6 Ot how injury occu		ny)	_
Affer Fune	100	1 Natural	5 Panding invastigati		of Injury oth, Day Year)	Injury	M	8c. Injui Woi 1 □	rk? Yas 2.	No		+ was		of	
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or Attendi after death. Director: A d in by the fu	Certification:	4 M Homicida	determine	build	e of Injury - At ho ling, etc. (Specify				20011		A .		remon	A Venue	
ours ours fille		29a. Certifier 1	☐ Certifying F	Physician: To the	a best of my know	treet					Baltime	-	annar as	stated.	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edicai			miner: On the b	pasis of axaminationar stated.										
o the o the o the o	-	29b. Signatura and tit	tla of certifier				290	Licans	sa number			29d. Data sign	ed (Month	Day, Year)	
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	-	30. Name and address	1001	11 /	wal	220 /n.	Drint'					2			-
M	7	So. Ivanie and addres	s of person who	0 1				~ .							
Ö		31. Date filed (Month	Day, Year)	Rade	Registrar's Signat	LII_E	enn s	Stre	et, I	3alti	more, l	Maryland	1_212	01	
State Registra	r	31. Date tiled (Month,	UG 23	2000	Berev-s		1	oon	W.						
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State of Maryland / Department of Health and Mental	Hygiene	0	n	2	-	_	0	gar.
Certificate of Death	Reg. No.	U	U	-	0	J	7	-

						Ce	rtificat	e of	Death		Re	g. No.	0 4	039	1
		1. Decedent's Nem		2.					2. Dete of Death Month Day Year 3. Time of Death						
Physicia /Medica		ALLAN	CZARNOWSK	ΥY							August		2000	01:24	P.M
Examine		la Facility Nama (/	If not institution, giv	ra <i>street</i> and nu	m <i>ber)</i>	11000	12.1		4b. City, To	wn, or Lo	cation of Death	4c. Count	y of Death		
			Good Sa	maritan	Hospit	al			Ва	ltimo	ore		N/A	1	
Funeral Director		5. Social Security N unk	1	M 2DF	7. Age (In yrs. 76	last birthday) Yrs.	If Unde Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 4,		9. Birthp Cour	place (State or F ntry) unk	oreign
P .	-	Usual Residence of 10e. State	Decedent 10b. County		10c Cit	y, Town or Lo	ncetion							Od. Inside City I	imite
• Maryla	Director	MD	N/A		100.04		imore							1X Yes 2	
fer death with the Marylan fems 23s or 28s-1 show		10e. Street and Nur 2910 Be	erwick Av	enue			10f. Zip	2123	34		10	og. Citizen of	What Cour JSA	ntry?	H
within 72 hours after death with the Maryland within 72 hours after death with the Maryland than "netural", or thems 23a or 28a-f show the Madical Exercises must be notified at	by Fur	11. Marital Status 1 Never Merri 3 Widowed	unk ied 2 Married 4 Divorced	12. Was Deci Armed Fo 1 Yes If Yes, Giv Year or D	2 □ No				Hispanic Orean, Mexical Specify:		ecify Yas or No- Rican, etc.)		ce - Americ ock, White, fy: W		
of 2 should be filed within 72 hours aft of 2 should be filed within 72 hours aft than Mental Hygiene. This marked other than "natural", or traumatic event, the Medical Event traumatic event, the Medical Event	Completed	(Spec	15. Decedent's Edify only highest gra		I-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	at Occup rk done se retire	pation duning mos d)	st of worki	ing	16b. Kind of E	Business/In	dustry	
d withing giene.	Ö	unk		unk			unk					un	k	CTALLS.	
Mental Hyginarked other	To Be	17. Fether's Nama unk	(First, Middla, Last,)					18. Moth	er's Name	e (First, Middle, N	Aaiden Sume	me)		
d 2 should Ih and Meni		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Maili	ing Addres	s (Street	and Numb	er or Rura	al Route Number,	City or Town	, Stete, Zip	Code)	
C TO NA IN		O.C.M.E.				111	Peni	St	reet	Balı	timore,	MD 21	201		
E E E	2		□ Cremation 3 □			Place of Disposemetery, cre	osition (Na	me of		1		20c. Location		own, State	
pemit. Pages 1 au Department of Hea Important: If Itsm: any Injury or othe phose.		21. Signature of	5 DOther (Specif	.,	irector	3	2 Name	'AAdar	ass of Facili	Board	1 655 W.	Balti	more	Street	
Physician /Medical Examiner		23a. Patr 1. Enter ti shock, or hea Immediate Cause (disease or condition resulting in death)	(Final	plications that cone ceuse on a	knos		yr (de of dy	ing, such es				se	Approximete interval Betwee Onset and Dec	
rifficate be ng physicia s as the bur	Medic	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i		b		or es a conse									
death cert e attending of for use	Physician	Part II. Other signif	licant conditions	contributing to de	eath but not res	ulting in the u	underlying	ceuse di	ven in Part	ł,	23b. Did to	bacco use c	ontribute t	o the cause of	death?
	by Phys				LI PILE						1 🗆 Yı	2 2 No	3□ Pro	bably 4 Ur	knowi
or Attending Physician: The law requires is after death. Director: After this centificate has been signed in by the funeral director, page 2 should be	Completed b		A Sister								24a. Was a perform	n autopsy ned?	av cc	fere sutopsy find vailable prior to emplation of cau death?	
The fig.	E										1 Acre	s 2 No	1	Yes 2 N	0
and diffice doc, p		25. Was case refer	red to medical						26. Plac	e of Deat	h (Check only on	e)			
yaidh S car direc	0	examiner?	No	Hospital:	Inpatient 20	ER/Outpatie	ni 3 D	OA OI	her: 4 N	ursing Ho	ma 5 Raside	ence 6 🗆 O	thar (Speci	fy)	
Ading Phy D.: Ather thi e funeral		27. Manner of Deat Natural 2 Accident	h 5 Pending investigation		4.50	28b. Time of Injury		28c. Inju Wo	ork? Yes 2		28d. Describe ho	ow injury occu	berru		
after Atten after dear Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place	of Injury - At hing, etc. (Specil	ome, farm, st	treet, factor	y, office			28f. Location (St City or Town		ber or Run	al Routa Numbe	r.
		29e. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	niner: On the b											9.4
within To the comple		29b. Signature and	title of gartifier	Λ			29	c. Lican	se number		2	9d. Date sign	ed (Month,	Day, Year)	
		* I	alorlo	141)				(D.C.M.	E.		Aum	ist 2	, 2000	
	3	10 Name and addr	ess of person who	completed caus	se of death (Iter										
I Designation	1	1. YAKE	N WG	Lomo)				et, I	Balti	more, Ma	aryland	3 212	01	
State Registra	e	Dete filed (Moni	2 3 2000	532. 8	legistrar's Signa	10	Sport	Es							



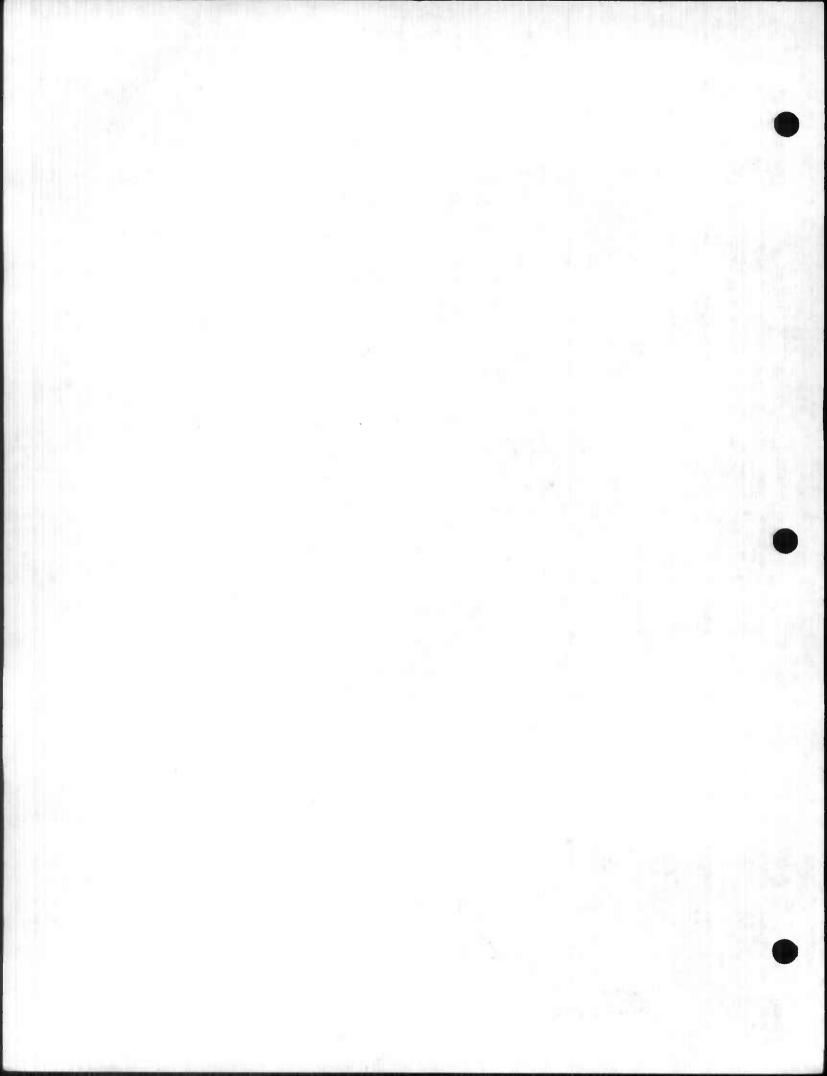
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State of Maryland / Department of Health and Mental Hygiene

mes (Clark			iai yiaiia i	Certificate (of Death		Reg. No.	0	26598				
		1. Decedent's Name (First, Middle,	Last)			2. Date of De		Voor	3. Tima of Death					
400	Physician /Medical	JAMES A. CLARK					June	23 2	2000	4:15 A.M.				
	Examiner	4a Facility Name (If not institution,	give street and number)	200	4b. City, Town, or	Location of Death	4c. County	of Death					
142		2503 Woodbrook				Baltimo		N/	Ά					
	Funeral Director	5. Social Security Number 220–38–8730	6. Sex 7. A 1 M 2 F	ge (In yrs. last t	Yrs. If Under 1 Y Months Da	ear If Under 24 Hrs lys Hours Min.		1943	9. Birthp Cour	place (State or Foreign htry) MD				
20		Usual Residence of Decedent		1										
» Marylar	and show diffed at	MD 10b. County N/A	A	10c. City, To	wn or Location Baltimore	9			1	1 No 1 No 2 No				
6 6 6	23e or 28e-f sho ust be notified at rai Director	10a. Street and Number 2503 Woodbrook	Avenue		10f. Zip Cod	21217		10g. Citizen of V	What Cour	ntry?				
020 ours after dea	Examiner in by Fune	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 N If Yes, Give Year or Dates:	? No	13. Was Decedent If Yes, specify 1 Yes 200	of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No to Rican, etc.)	14. Rac Blac Specify	k, White,	can Indian, etc. lack				
5-0	lical feet	15. Decedent's	Education	16	a. Decedent's Usuai Oc (Give kind of work di life. DO NOT use re	ccupation	relina	16b. Kind of Bu	siness/In	dustry				
Maryland 21215-0020	ver than "natur 4, the Medical Completed	(Specify only highest Elementery/Secondary (0-12) unk	Coflege (1-4or unk	5+)	life. DO NOT use re		irking		none					
P i	d other event,	17. Fether's Name (First, Middle, L.	est)			18. Mother's Na	me (First, Middle,	Maiden Sumam	10)					
rlar Jdbi	for B	James Clark				Sophia	а							
any any	Dan L	19e. Informant's Neme/Reletionshi	ip (Type, Print)	19	b. Mailing Address (St			er, City or Town,	State, Zij.	Code)				
Z 5	127	Wayne Clark/son			213 Allend	lale St Ba	altimore	, MD 21	1229					
more,	ant of Hear It: If Rem y or othe	20a. Method of Disposition 1 Burial 2 Cremation		ceme	ace of Disposition (Name of melery, crematory or other place) Date 20c. Location - City or Town, State									
Baltimore	Departme Importan any injur anse.		1. Signature State State Anatomy Board 655 W. Baltimore, MD 21201											
//	nysician Medical caminer	23a. Enter the disease, or or how or heart failure. List of limmediate Cause (Final disease or condition resulting in death)	nly one ceuse on each	nsive A	rterioscle	dying, such as cardia	c or respiratory a		ase	Approximate triterval Between Onset and Death				
8	aliner aline		b .	Due to (or es	e consequence of):				- 1					
68760, ificate be executed	physician and s the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequence of):											
	0 6	that initiated events resulting in death) Last	d	Due to (or as a consequence of):										
Box eath cer	d by the attendinetached for use. Physician/M	De All Colors de l'Oran Augustin		h		and the Bright	non- find	hah anna 1111 an		- the cause of death 2				
0 8	by the lached	Part II. Other significant condition	s contributing to death	but not resulting	in the underlying ceus	e given in Part I.				o the causs of death?				
D te	detac						10	Yss 2 No	3 Pro	bably 47 Unknown				
of Vital Records, P.O. Box Physician: The law requires that the death cer	page 2 should be de Completed by F						24a. Was	an autopsy	av	fere autopsy findings railable prior to empletion of cause				
law law	has h						Insp	ection	of	death?				
E &	page Com						10	Yes 2 No	1	☐ Yes 2☐ No				
of Vita	certificate rector, pag	25. Wes case referred to medicet examiner?				- 1	eath (Check only o	one)						
To se	this of the office of the offi	12 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ER/0	Outpatient 3□ DOA	Other: 4 Nursing	Home 5 ☐ Resi	dence 6 MOth	er (Speci	wat scene				
Vision o	ath. r: After the be funera	27. Manner of Death 1X Natural 5 Pending 2 Accident investigs		ay Year) 28b	. Time of lnjury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red					
Division	rs after death. I Director: After the line by the funera Certification:	3 Suicide 6 Coutd no determin	200. Place of it	njury - At home, atc. (Specify)	farm, street, fectory, of	lice	28f. Location (City or To		er or Run	al Route Number,				
- Hospital	within 24 hours after To the Funeral Dire completely filled in b Medical Certi		Physician: To the best xaminer: On the basis and menner s	of examinetion a										
To the	To the comp	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, July 31, 200												
		30. Name and address of person w	no completed ceuse of	A		n Street,	Baltimo	re, Mary	land	21201				
	State Registrar	31. Date file A Ward Saig Year)	11	trar's Signature	4 1					1114				
			/											

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State of Maryland / Department of Health and Mental Hygiene 00 26599

						Ce	rtifica	ite of	Death			Reg. No.			
No. of the	_	1. Decedent's Nama (Fire	st, Middla, La	st)						1	2. Date of De Month		Year	3. Tim	e of Death
Physicia		Matthew Par	ul Cra	wley, J	r.						AUGUS	T 19	2000	03:	18 PM
/Medica Examine	_	4a Facility Nama (If not i	institution, giv	a street and nur	nber)				4b. City, To	wn, or Lo	cation of Deal	h 4c. Coun	ty of Death		
		ST. AGNES +			7. Age (In yrs.	last birthday) If Und	ar 1 Yee			8. Date of Bi	rth	C(MOR	-	ata or Foreign
Funeral Director		216-62-140	3	IÊM 2□F	r. Ago (m y/o.	45 Yrs.	Months			Min.	Jun 10	1955	MD Cou	ntry)	ata or 7 oreign
ž	1	Usual Rasidence of Dece 10a. Stata 10b.	. County		10c. Ci	ty, Town or L	ocation						11	10d. Insid	a City Limits
e Maryl Se-f sho diffed a	Director		I/A		3.1	ltimor								12	Yes 2□No
		10e. Street and Number 603 Edgewood	od Stre	eet				ip Code 229				10g. Citizan o United		1	
	by Funeral	11. Maritel Status 1 Nevar Married 3 Widowed 4 1		12. Was Dece Armad For 1 Yas ff Yas, Giv Year or De	2 No	l,S. 13.	Was Dec If Yas, sp 1 ☐ Yas	2.0			ecify Yas or N Rican, etc.)	В	ace - Amaric ack, Whita, ack		n,
5-0 72 ho	ted	15. I	Decedant's E	ducetion eda complated)		16a. Dece	edent's Us	ual Occu	pation during mos	t of work	ina	16b. Kind of			311
2121 within lene. than	Completed	Elamentary/Secondary		Collega (1	-4or 5+)	lifa.	tena:	usa ratin	ed)	e or work	· ·y	Federa	al Gov	ernm	ent
D STEP	o Be C	17. Father's Nama (First, Matthew Pa			r.	FTI					(First, Middle	ms	ama)		
Mary nd 2 shou alth and M 27 is mar r traumet		19a. fnformant's Name/F			fe		-					ber, City or Tow more, M			175
Pages 1 a sent of Hear rry or other		20a. Mathod of Disposition 1 Durlal 2 Cra 4 Donetion 5	mation 3 [State	Place of Disponentary, cra	matory or	othar pl			Dete Aug 24 1900	20c. Location Randa			
Balti permit. Departm importa eny loju		21. Signature of Funaral	Sarvice Lice	nsee I	unt	2	2. Nama Smit	and Addi	ess of Facili Williams t Bal	ams i	Funeral re Stre	Home,	P.A. Ltimor	re, M	ID .
-	-	23a. Part1. Enter the dis	aasa, or com	olications that c	eusad tha daa	th. Do not an	ntar tha m	oda of dy	ing, such as	cardiac o	or raspiratory	arrast.		Approx	imata
	Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last		b. LIVE	Dua to (i Dua to (i TEO	RHOS(S or as a conse	equance o	1): 1): 1) PA 7		HENG	ORHAG	SIC SHO		MONT YE	HOURS THS TO THS TO EARS
Box 6 leath certific attending p	an/Me		•	d											
.O. Bo	Physician	Part II. Other significant	conditions	contributing to de	eath but not ras	sulting in tha	undarlying	ceusa g	iven in Part	l.	23b. Dic	I tobacco uee d	contributa t	o the cer	use of death?
- AD	by Ph					16,					1	Yee 2□ No	3 □ Pro	bably	4 Onknown
requirements	Completed		110		123	KY.	- 23					s an autopsy lormed?	av cc	vailable p	psy findings rior to n of ceuse
Vital Rec	E										10	Yas 200 No	1	□Yas	2 DNo
Vital Sicien: T		25. Was cesa rafarrad to	medicel		1377				26 Place	a of Deat	h (Check only	ona)			
	0	examiner? 1 ☐ Yas 2 ☐ No		Hospital:	npatiant 2	ER/Outpatie	ent 3 🗆 I	DOA O	thar			idance 6 🗆 C	thar (Speci	itu)	
O f f 5		27. Manner of Death 1 Netural 5	Pending	28a. Data (Mont		28b. Tima Injury		28c. Inj				how Injury occ		-97	
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accidant 3 Suicida 6 4 Homloida	invastigetio Could not b datarmined	e 28e. Plece	of fnjury - At h	ome, farm, s					28f. Location City or To	(Street and Nul own, Stete)	mber or Rur	al Route	Number,
To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1년 (Check only 2 1	Certifying Ph Medical Exar	nysician: To the miner: On tha be and mann	sis of axamina	owledge, dee ation and/or in	th occurre	d et the	time, date ar opinion, das	nd plece, ath occurr	end due to the red at tha time	causa(s) and , deta and plac	mannar as : e, and due !	stated. to the cau	use(s)
Nithir To th	-	29b. Signeture end titla o	of certifiar			1116	2	9c. Licer	sa number			29d. Data sig	ned (Month,	Day, Ye	ar)
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0		30. Nama and addrass of								1		1111			2.00
State	e	Mo HAMMO 31. Data filed (Month, Da	y, Year)		egistrar's Sign		NA	VEN	06/16	ALTI	MORE	MARY	CAND	di	129
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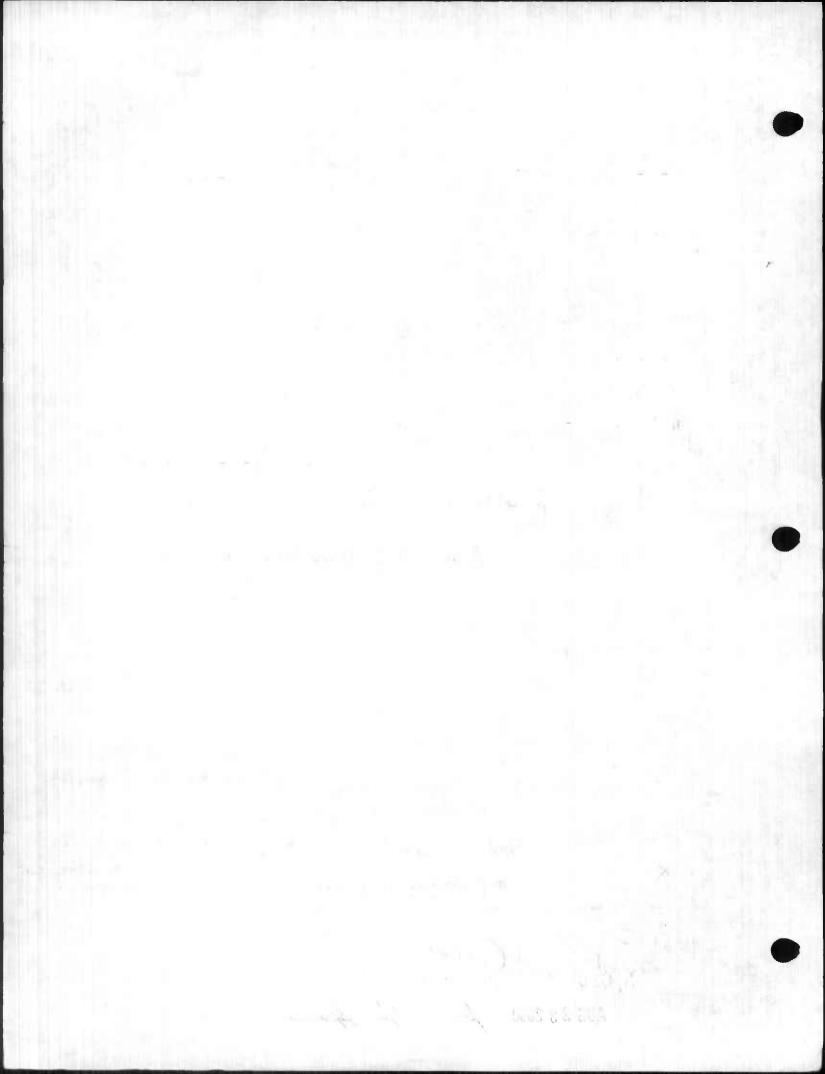
MATTHEW CRAWLEY



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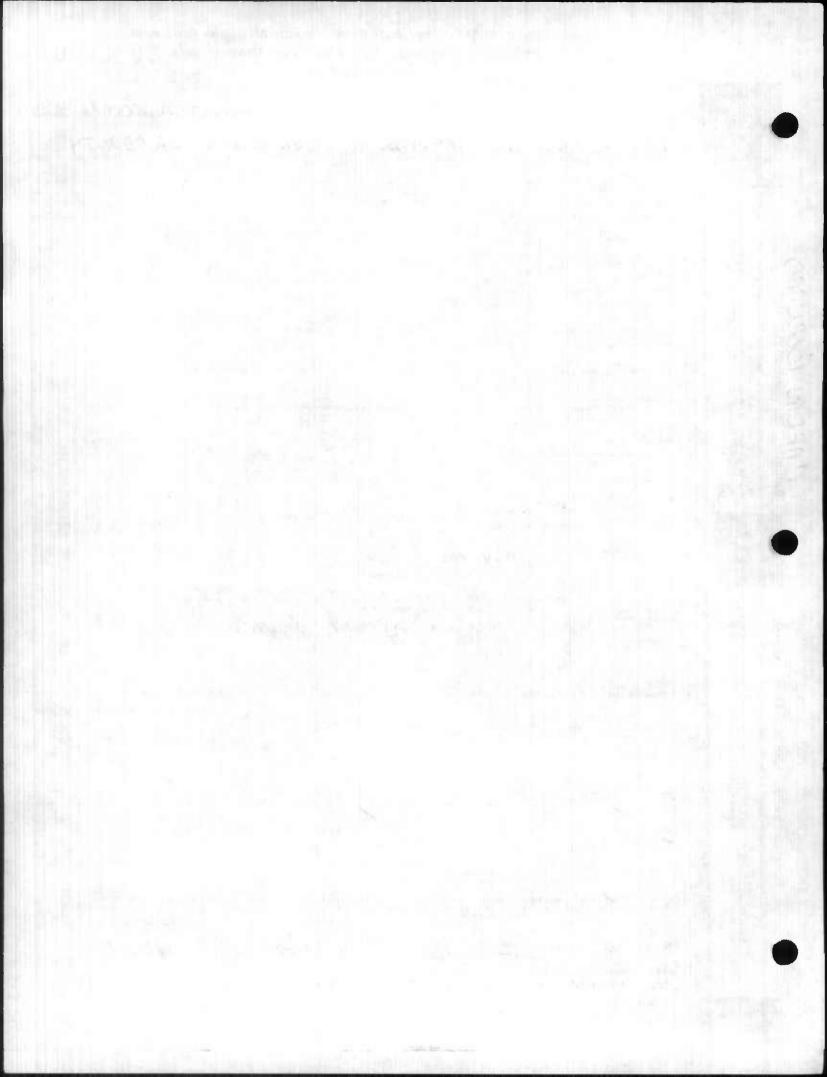
State of Maryland / Department of Health and Mental Hygiene 00 26600

			Certific	cate of	Death		Reg. No.		
Physician	1. Decedent's Neme (First, Middle, Las	John H. Cu	ntic			Month			
/Medical Examiner	4a Facility Name (If not institution, give 3300 GARRISON BL	street and number)	1 013			AUGUS on, or Location of De IMORE CIT	ath 4c. County	2000 of Death	2134 PM
Funeral Director	5. Social Security Number 6. Se			Inder 1 Yeer oths Days	If Under 2 Hours	Min. (Month,	Birth Dey, Year) -1966	9. Birthp Coun	place (State or Foreign N.Y.
Pland Now M	Usual Residence of Decedent 10a. Stete 10b. County	10c. Ci	ly, Town or Location	n			-1300	1	0d. Inside City Limits
or 28ef st be notified Director	Md N/	A Bal	timore	f. Zip Code			10g. Citizen of	What Coun	YYes 2 No
		d		21229			USA	P	
al', or have 23s Examiner mat by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:		Decedent of I specify Cub		in? (Specify Yes or Puerto Rican, etc.)	Bla	ck, White,	etc.
ad within 72 ho ygiens. wr than "neturn 4, the Medical. Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) G. E. D.	ucation de completed) College (1-4or 5+) N/A	16e. Decedent's (Give kind life. DO N	Usual Occup of work done OT use retire	during most	of working	16b. Kind of B	usiness/inc	dustry Unk
And the filed fental Hyg had other tic event,	17. Fether's Name (First, Middle, Last)					rs Name (First, Midd il Curtis	lle, Maiden Surnar	ne)	11/2
2 shows and M is man	19a. thlormant's Name/Relationship (7) Sybil Emerson - M		19b. Mailing Ad		and Number	r or Rural Route Nur	nber, City or Town		Code)
ages 1 and int of Health to it flees 27 y or other to	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	20b. I Removal from State	Plece of Disposition cametery, cremator	(Name of y or other ple	ce)	Date	20c. Location	- City or To	
Departit. P Departme Importan any Injur 2058.	21. Sign up of Funeral Service Licen		Ma	arch F	H We	1	O Catons		
that the deeth certificate be executed ed by the ettending physician and deteched for use as the buntal-transit Physician Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or es a consequence	e of):	W St	107 WO	UNDS		
es that the deeth crigned by the ettend be detached for us by Physician	Pert II. Other significant conditions co	ontributing to death but not res	sulting in the underly	ying cause gi	ven in Part I.		10		o the cause of deat
8 60 0						24a. W	as an autopsy	24b. W	ere autopsy findings allable prior to impletion of cause
has to be 2 s			tye jil	155	14.5	11	Aoyes 2□No	of	death?
clan.	25. Was case referred to medical examiner?	Hospitat:		0	h a s.	of Death (Check on			
He light	1 Yes 2 No 27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Descrit	BSECT C	NAS	
24 7 E	3 Suicide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Special	ome, larm, street, f fy) TION SION		1	28f. Location City or	n (Street and Num Town, State) 33 3 ALTIMO		ARRESON BL
Within 24 hours a To the Funeral Completely filled	29a. Certifier 1 Certifying Phy (Check only one) Medical Exam	ralcian: To the best of my kno Iner: On the basis of examina and manner stated.	owledge, death occi ation and/or investig	urred at the t pation, in my	me, date and opinion, deat	d place, and due to the hoccurred at the time	he cause(s) and m ne, date and place,	anner as a , and due to	stated. o the cause(s)
To the comple	29b. Signature end title of certilier	W.M.	0	29c. Licen	se number		29d. Date signe AUGUS		
3	30. Name and address person who g	completed cause of death (Item			t, Bal	timore, M	aryland	21201	
State Registrar	31. Date filed (Month, Day, Year) AUG 2 3	32. Registrar's Signi	atura . A	1	a Ka				



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		Otate of Mar		rtificate o		Re	g. No.		0001			
Physician	Decedant's Neme (First, Middle, La.					2. Date of Death Month Day Yes			3. Time of Death			
/Medical	BERNARD	J.	CARLI	N	I	Augus	21.2	000	6:32am			
Examiner	4a Fecility Nema (If not institution, giv		11	A .	4b. City, Town, or I	0	4c. County					
		UNDEL	HOSPITI	If Under 1 Yas	ar If Undar 24 Hrs.	DURNIE	MAC	COUN				
Funeral Director	5. Social Sacurity Number 6. S 471–24–5198 Usuat Residence of Decedent	D	n yrs. last birthday) 14 Yrs.	Months Day			²⁶ , 192	5 MN	ca (Ståta or Foreign y)			
E	10a. Stata 10b. County	10	Oc. City, Town or Lo	ocation				100	d. Inside City Limits			
Mary Heats find a	MARYLAND ANNE A	RUNDEL	ŀ	HANOVER					1 ☐ Yes 2 🖾 No			
or the Ma to thete be notified	10e. Street and Number			10f. Zip Code	9	10	g. Citizen of V	n of What Country?				
	7574 CARLIN ROAD				21076		U.S	5.A.				
urs after death vir. or flame 236 Examiner must by Funeral	11. Merital Status 1 Never Merried Married 3 Widowed 4 Divorced	12. Was Decedant Eva Armed Forces? 1 12 Yes 2 No If Yas, Giva Year or Datas:	244-	Wes Decedent of Yas, specify Co	of Hispanic Origin? (Suban, Maxican, Puart lo Specify:	pecify Yas or No- o Rican, atc.)		e - Amaricar ck, White, at WHI	c.			
	15. Decedant's Ed		16a Dece	dent's Usuel Occ	cupetion		6b. Kind of Bu					
ed within 72 ho ygens. ygens. t, the Medical.	(Specify only highast gra	da completed)	(Giva	kind of work don DO NOT usa ret	na during most of wor	rking		. J	,			
The Party Omo	Elamentary/Secondary (0-12)	Collega (1-4or 5+)	ANAL				U.S.	GOVERN	MENT			
a other	17. Fethar's Name (First, Middle, Last,		a minist		18. Mothar's Nar	na (First, Middle, A	faidan Sumam	ia)				
Asmirand Member of the say	JOHN		CARLIN		IDA		LAT	TEREL	ıL			
and h	19a. Informant's Name/Raletionship (Type, Print)	19b. Malli	ing Addrass (Stre	et and Number or Ru	ıral Routa Number	City or Town,	Stete, Zip C	Code)			
27 in 127	MARIE M. CARLIN	(WIFE)	7574	4 CARLIN	ROAD, HOA	ANOVER, M	D. 2107	76				
nerif of Ha mt: If Ham my or other	20a. Mathod of Disposition 1 Burlal 2 XX ramation 3 5 4 Donation 5 Other (Specif	Ramoval from Stata		matory or other p	olace) ATION CEN	2126 2000	STEVI		m, State			
Departri Importa any inju	21. Signal and Address of Fecility SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrast.											
	23a. Part 1. Entar tha diseasa, or com	plications that caused the	a daeth. Do not an	iter tha moda of c	tying, such as cardia	or respiretory arm	ist,	1	Approximate Intervat Betwaan			
nysician Medical	shock, or heart feilure. List only								Onset end Death			
Examiner	Immediata Causa (Finel disaasa or condition rasulting in death)	a ASYST	TOLE					1				
- E	Dua to (or as a consaquanca of):											
nsıt		b. AC476	= 1400	CARDIA	ZINFA	RCTION						
n and ial-transit Examiner	Sequantially list conditions, if any, leeding to immadieta cause. Enter Underlying Cause (Disassa or injury that initiated evants	Du	a to (or as a conse	quence of):	0 0,00	1-15		1				
	Cause (Disaasa or injury that initiated evants				1 11156.	456						
0 .	rasulting in death) Last	Du	a to (or as a consa	quance of):								
for use a		d										
e att	Part II. Other significant conditions of	ontributing to death but r	not resulting In the	undarlying causa	givan in Pert I.	23b. Dld to	bacco uss co	ntribute to 1	the causs of death?			
detached		1 5 10			18/11/	1 🗆 Y	8 2 No	3 Prob	ably 4 Unknown			
beng of you												
cate has been signed by the attending page 2 should be detached for use Completed by Physician/N						24a. Was a	n autopsy ned?	svai	e autopsy findings lable prior to			
as bee				100		, , , , , , , , , , , , , , , , , , , ,		com	plation of causa eath?			
page 2						1 🗆 Ya	s 20 No	10	Yes 2 No			
certificate rector, pag	25. Was casa rafarred to medical				26. Placa of Da	eth (Check only on	a)					
nis certific il director. To Be	examinar?	Hospitat: 1 ☐ Inpatient	2 ER/Outpatie	ent 30 DOA	Other	loma 5□ Raside		er (Specify)				
	27. Manner of Death	28a. Data of Injury (Month, Day Y	ear) 28b. Tima (of 28c. In	njury at Nork?	28d. Dascribe ho	w injury occur	red				
Attending ir death. ector: After by the fune iffication	2 Accident Invastigatio	n		M 1	☐ Yas 2☐ No							
after de la Directe de in by ti	3 Suicide 6 Could not be determined	28a. Place of Injury building, etc. (- At homa, farm, st Specify)	treet, factory, offi	ce	28f. Location (St City or Town		per or Rural	Routa Number,			
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		ysician: To the best of n niner: On the basis of ax and mannar stete	amination and/or in									
Vithin Forth	29b. Signature and titla of certifiar	., 0		29c. Lica	anse number	2	9d. Data signe		ay, Year)			
	I ant When	rallwas	ni	Do	052490		8/2:	2/00				
0	30. Nama and addrass of person who Anita Khandellw	completed causa of deat al MD, 3	h (Itam 23a) (Type	Print) He Hence	ove skee	& Balki			25			
State	31. Data filed (Month, Day, Year)	32. Registrer's	Signeture									
State		32. Registrer's	Signeture App	uls	VE SNEE		WAS TOU) ale	, 29			



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 26602 Certificate of Death 3. Time of Death 2. Data of Death City, Town, or Location of De FLEN BUMIE If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign Deys 1 M 2 □ F Yrs 292-54-9622 47 OH Usual Residence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yes 35 No MD Anne Arundel Crownsville 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number U.S.A 21032 329 South River Side Drive 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ≦ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, atc. 1 Naver Married 2 Married White 1 ☐ Yas 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifta. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Waiter Restaurant 18. Mothar's Nama (First, Middla, Melden Sumame) 17. Fathar's Nama (First, Middle, Last) Delbert Chesher Barbara Beczynski 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Teresa Groll/ Sister 330 North Norden Road Oregon Ohio 43618 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removal from Stata Chesapeake Cremation 8-22-2000 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama and Addrass of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Libersed 1 Second Ave. S.W. Glen Burnie, MD 21061 one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finel disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaase or Injury Dua to (or as a consequence of) that initiated events resulting in deeth) Last Due to (or as a consequenca of) 23b. Did tobecco use contributa to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown 24b. Wera eutopsy findings available prior to 24a. Was an eutopsy complation of causa of death? 1 Yas 2 12 No 1 ☐ Yas 2 ☐ No 25. Was gase referred to medical 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) t D You 2 No 1 Inpatiant 2 PR/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Maryler of Death 28b. Time of 28d. Dascribe how Injury occurred s ENatural 5 ☐ Pending

physician and the burial-transit requires that the deeth certificate be executed Division of Vital Records. P.O. Box 68760. 88 use ò signed by the e peed pege 2 hes certificate or Attending Physician:

Physician /Medical

Examiner

Physician/Medical Completed by Be

Medical

Examiner Certification: To this funeral After after death. filled in by • Funeral

Physician /Medical

Examine

Funeral

Director

r 28a-f show

"natural", or items 23s or edical Examiner insist be-

permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Nems 23, any injury or other traumatic event, the Medical Eventure.

Saltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

with the Meryland

29a. Certifier (Check only 29b. Signati

2 Accident

3 Suicide

4 Homicide

investiga 5 ☐ Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and piace, and dua to tha causa(s) and mannar es stated.
2 Medical Examinar: On the basis of examinetion end/or invastigation, in my opinion, daath occurred at the time, date end piace, and due to tha cause(s) and mannar statad.

29c. Licanse number

29d. Date signed (Month, Day. Year)

use of death (item 23a) (Type, Print) 31. Data filed (Month, Day,

State Registrar

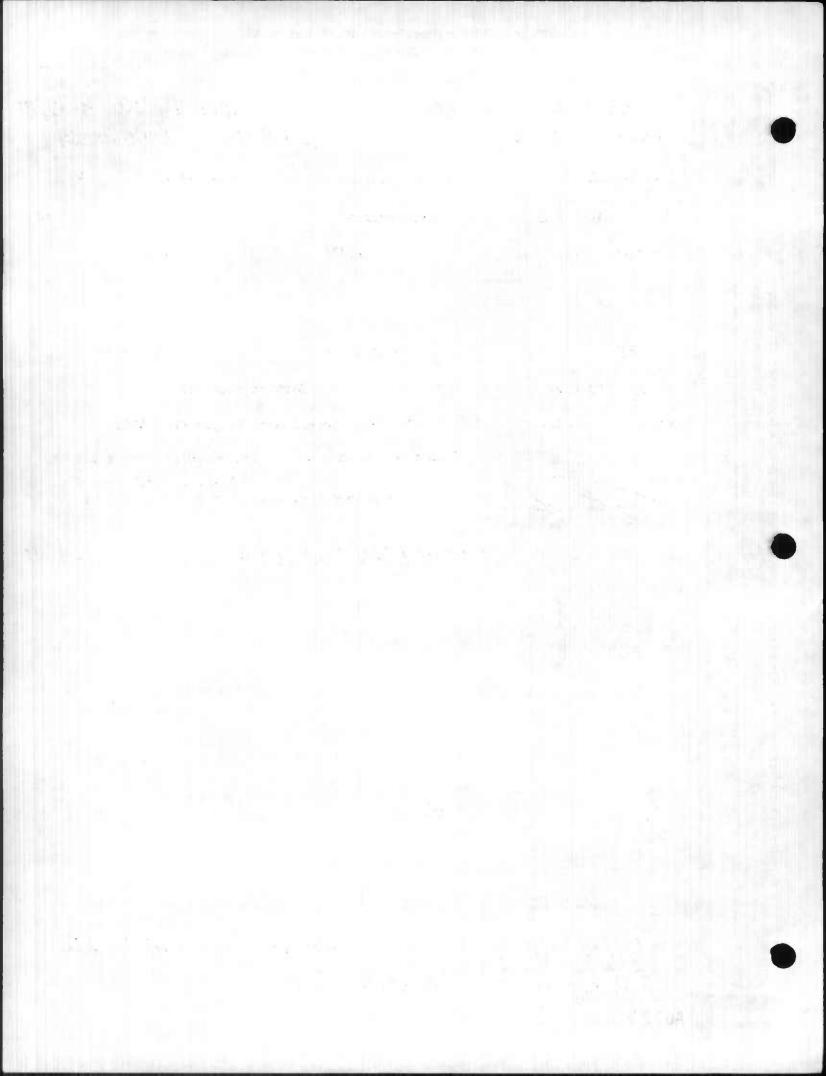
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AUG 23 2000 32. Ragistrar's Şignatura

DHMH 16 Rev 6/95

Hospital

To the Vithin 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Amended item#1 per ME G786 8-23-00 WJJ Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death YMETER Zymeter Cherry-Carter **Physician** 1841 4b. City, Town, or Location of Death 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Undar 1 Year | If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Data of Birth (Month, Day, Year) **Funeral** Days Hours 10M POF 48 Yrs 214-56-9675 Director 29,1952 MARYLAND Usual Residence of Decedant 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 23a or 28a-f ahon the Medical Examiner nast be nothed at 1 XYas 2 □ No Director BALTIMORE Md. N/A 10a, Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21202 U.S.A. 1219 E. LAFAYETTE AVENUE Funeral death 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) or Nems 11 Marital Status AFRO-AMERICAN filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 No by 3 Widowed 4 Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Hygiena. Elementary/Secondery (0-12) College (1-4or 5+)

YEAR

17. Fathar'a Nama (First, Middla, Last)

SHENITA

20a Mathod of Disposition

Immedieta Causa (Final disaasa or condition rasulting in death)

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events.

25. Was casa rafarred to medicel axaminar?

29b. Signatura and titla of certifier

1 Yas 2 No

27. Mennar of Death

t X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homlcida

that initiated evants rasulting in death) Last

ALVIN STEWART SR.

WHITFIELD

1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Othar (Specify)

19a. Informent's Neme/Ralationahip (Type, Print)

21. Signatura of Funaral Sarvice Licensee

COMPUTOR OPERATOR

22. Nama and Addrass of Facility

20b. Place of Disposition (Nama of cematary, crametory or other place)

23a. Partf. Enter the disease, or complications that muse the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each time.

Cardion yopathy
Due to (or es e consequence of):

Congestive Heart Failure

Anoxic brain injury

Dua to (or as a consequence of)

Hospital: 2 ER/Outpatient 3 DOA

28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dua to (or as a consaquance of):

KING MEMORIAL PARK

Physician /Medical Examiner

other

in end Mental I. Pages 1 and 2 should be

nt of Health of: If Itam 27 It

Department of Important: If any Injury or

director, page 2 should be detached á this certificate has After the

The law requires that the daeth certificate be execut

Box 68760. P.O. Division of Vital Records, or Attanding Physician: efter deeth filled in by

Physician/Medical Examiner Be Completed by

Medical Certification: To To the Hospital within 24 hours e To the Funeral C

DHMH 16 Rev 6/95

State Registrar

Ron Elfenbein 31. Data filed (Month, Day, Year) AUG 23

Johns Hopkin

29c. Licansa number

Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yas 2 No

29d. Data signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to complation of cause of death?

1 Yas 2 No

WAVERLY PRESS INC.

20c. Location - City or Town, Stata

21212 Approximata Intervel Between Onsat and Death

wee trs

AUG. 23, 2000BALTO, MD.

18. Mothar's Nama (First, Middla, Maiden Sumama)

MABLE HENDERSON

Dete

19b. Meiling Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Code)

1230 E. NORTH AVENUE BALTO, MD. 21202

CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD.

30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print)

600 N. Wolfe St. Beltimore MO 21287

24a. Was an autopsy performad?

1 Yas

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

26. Placa of Deeth (Check only one)

2 No

32. Registrar's Signatura

ORIGINAL

5 Pending invastigation

6 Could not be

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Frances Louise Conner 2000 4:00 P.M. August 17 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Anne Arundel 5106 Brookwood Road If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 M 2K) F 242 26 1156 77 12, 1923 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Maryland Anne Arundel Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21225 5106 Brockwood Road 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status 14. Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Narried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Department Store Assistant Manager 12th 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pearl Brack Everett Lambeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
213 Winston Road Pasadena, Maryland 21122 19a. Informant's Name/Relationship (Type, Print) David Conner 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other p. 20c. Location - City or Town, State 1 ☐ Burlat 2 ☐ Cremation 3 ☐ Removal from State 8/22/00 Towson, Maryland Hilltop Service Corp. 4 ☐ Donetion 5 ☐ Other (Specify) Gonce Funeral Home P.A. of Funeral Service License 22. Name end Address of Facility 4001 Ritchie Highway Baltimore, Md. 21225 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or respiratory arrest, and cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mxocardia disease or condition resulting in death) erioscleratic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown Hypothyroidism 1 Yea 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

important: If eny injury o Department

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23s or 28s-f show Examiner must be notified at

"natural", or

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. unt; If item 27 is marked other than "Iny or other traumatic event, the Mental Iny or other traumatic event, the Mental Ing.

Director

Funeral

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Completed

Be

the Maryland

72 hours after death with

Baltimore, Maryland 21215-0020

Examiner Physician/Medical py Completed Be

The law requires that the death certificate be axecuted and signed by the Affer death.

Box 68760 P.O. Division of Vital Records. or Attending Physicien: Medical Certification: To To the Hospital or Attention within 24 hours after deal To the Funeral Director:

completaly

State

Registrar **DHMH 16 Rev 6/95**

aute

5 Pending Investigation

6 Could not be

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Maturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number 10014

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Presidence 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Typq, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

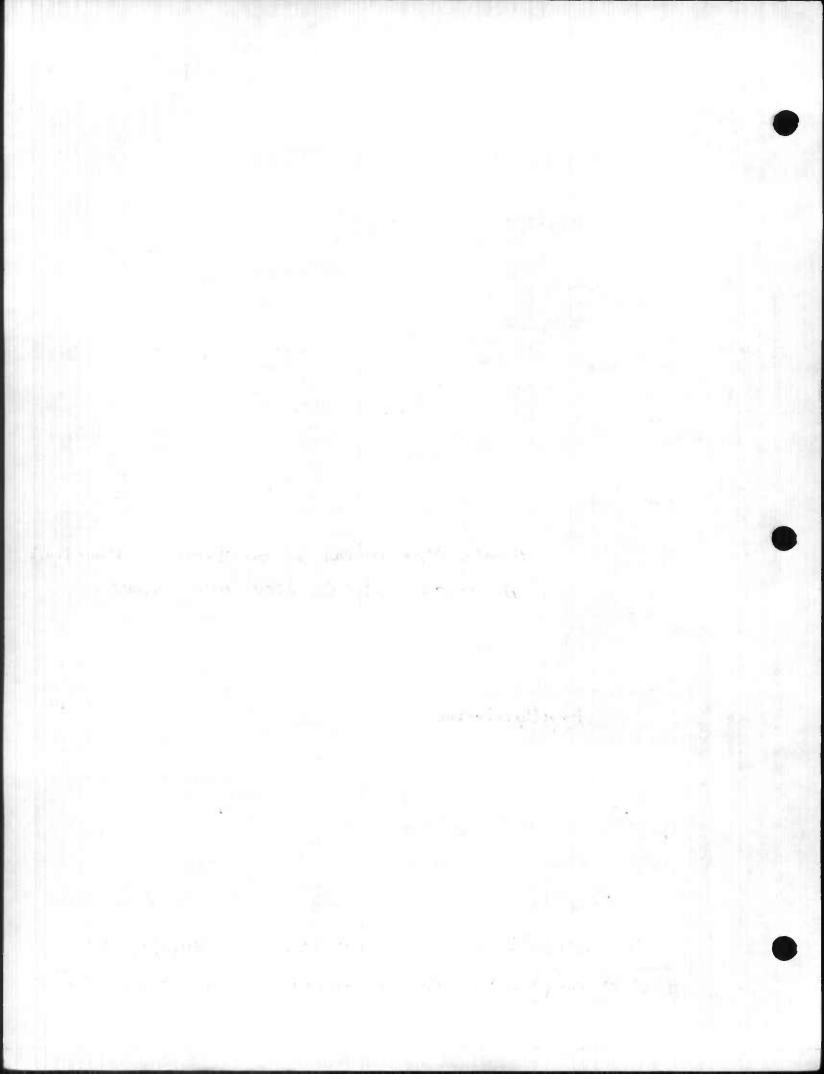
Ave. Sal Colvin C Carter 21226 more, m

31. Date filed (Month, PAUG')2 3 Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
4,10 AM **Physician** Evelyn S. Clay August 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner NORTH ARUNDEL GLEN BYENIE HOSPITAL ANNEARUNDEL H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 10 M 280 F 578 14 9606 88 Virginia Oct. 16, 1911 **Usual Residence of Decedent** 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Maryland | Anne Arundel Millersville 10s. Street and Number 10f Zin Code 10g. Citizen of What Country? 21108 U.S. 8211 Rupert Road North 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Esta Borden Charles J. Sager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 8211 Rupert Road North Millersville, Maryland Harry L. Clay / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/23/00 Woodstock, Virginia Sager Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. keome gramuourfu 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Intracevebral themorrhage Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of) pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown zheimers Disense Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investiga 1 Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be assecuted Box 68760, P.O. Records, of Vital Attending Physician: Division To the Hospital within 24 hours a To the Funeral D

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

.. Peges 1 and 2 should be filled w tment of Health and Mental Hygler tant: If Item 27 is marked other th jury or other traumatic event, that

permit. Pege Department of Important: If eny injury or page.

Physician

/Medical Examiner

for use

certificate

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s after deetl

funeral director,

filled in by

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8

Certification: To

Medical

29a. Certifie (Check only one)

Maryland

altimore.

CLAY

DHMH 16 Rev 6/95

Registrar

E. Will III M.D.

32. Aggistuace Signature

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death Otem 23a) (Type, Print)
GEOVGE E. WICKS DE 17.D. 301 HOS potal Drive Glen Burnie, MD, 21061

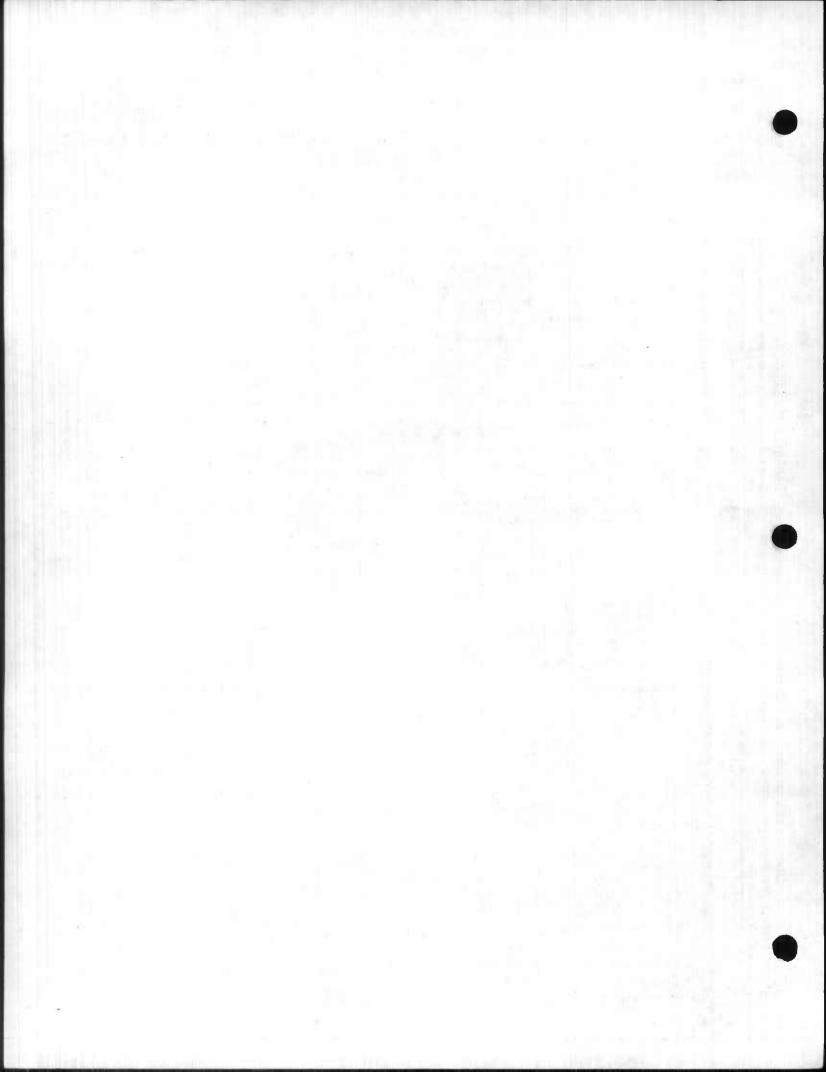
doorke

29c. License number

D4 1365

29d. Date signed (Month, Day, Year)

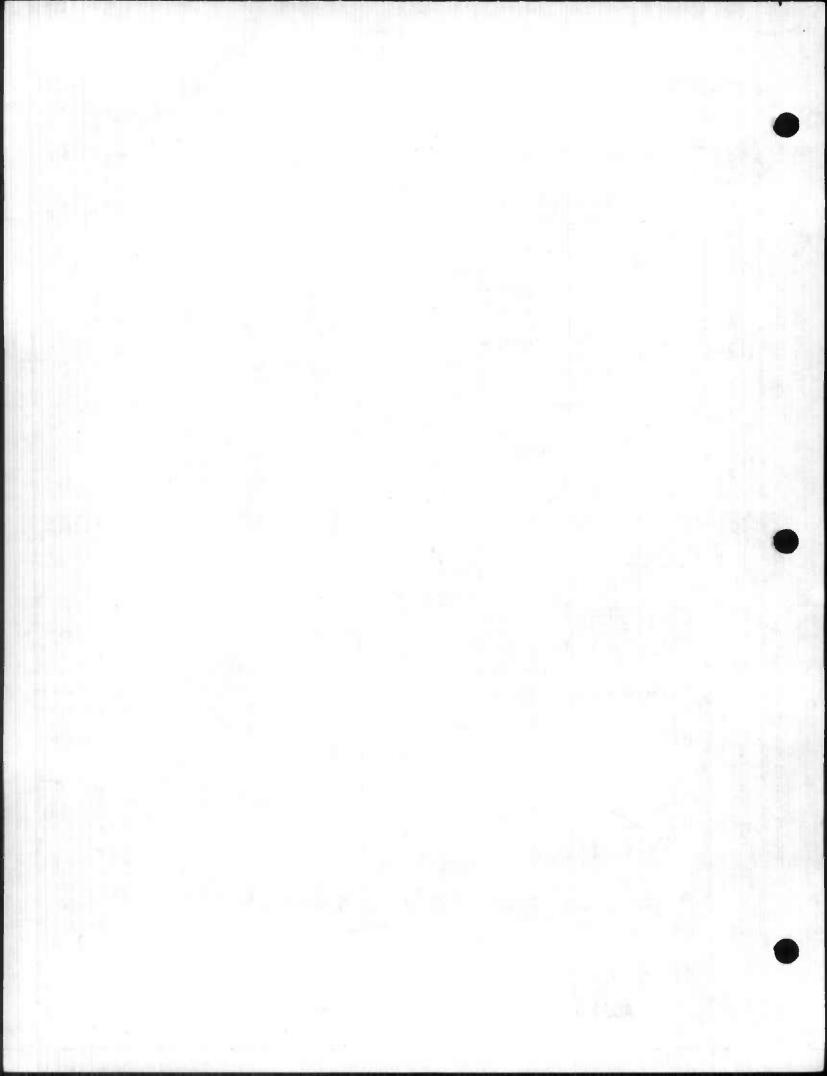
August 20, 2000



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010	Decedent's Name (First, Middle, Last) Naomi Carlsen	2 M	Reg. No. le of Death inth Day Year 3. Time of Death
ledical aminer eral ctor	4a Facility Name (If not institution, give street and number) North Arundel Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	Glen Burn	e of Birth onth, Day, Year) 9. Birthplace (State or Fore Country)
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limi
tor	Maryland Carroll Lusby		1 Yes 201
al Direct	10e. Street and Number 11180 Cove Lake Road 2	Code 20657	10g. Citizen of What Country? U.S.
by Funeral	1 Never Married 2 Married 1 Yes 2K) No	ent of Hispanic Origin? (Specify Ye ify Cuban, Mexican, Puerto Rican, In No Specify:	s or No- etc.) 14. Race - American Indien, Black, White, etc. Specify: White
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th 16a. Decedent's Usual (Give kind of word life. DO NOT use life. DO NOT use life. DO NOT use life. DO NOT use life.	of Occupation of done during most of working the retired)	16b. Kind of Business/Industry Own Home
Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)
2	George Hartung		ae Stuart
			o Number, City or Town, State, Zip Code) Prince Frederick, Md. 20
	20a. Method of Disposition 1	ne of Date ther place)	20c. Location - City or Town, State
	21. Signature of Funerel Service Licensee 22. Name end	d Address of Fecility Gond	ce Funeral Home P.A. Baltimore, Md. 21225
sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ONTA	
VMedical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):		
	that ribated events resulting in death) Last Due to (or es a consequence of):	ause given in Pert I. 23	Bb. Did lobacco usa contributa to the cause of dear
Physician/M	resulting in death) Last Due to (or es a consequence of):	ause given in Pert I. 23	3b. Did tobacco usa contributa to the cause of dear
by Physician/M	resulting in death) Last Due to (or es a consequence of):		1 Yes 2 No 3 Probably 4 Unknown with the Unknown of the Wes an autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death?
Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying ca		1 Yes 2 No 3 Probably 4 Unknown Unknown Unknown 24b. Were autopsy finding aveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
To Be Completed by Physician/M	Due to (or es a consequence of): d	26. Place of Death (Check A) Other: 4 Nursing Home 5	1 Yes 2 No 3 Probably 4 Unknown Unknown Unknown 24b. Were autopsy finding aveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
To Be Completed by Physician/M	Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ca 25. Was case referred to medicat examiner? 1 Yes 25 No	26. Place of Death (Check A) Other: 4 Nursing Home 5 8c. Injury at Work? 1 Yes 2 No office 28f. Lo	1 Yes 2 No 3 Probably 4 Unknown Unknown Unknown 24b. Were autopsy finding aveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No Xe only one)
edical Certification: To Be Completed by Physician/M	Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying categories.	26. Place of Death (Check A) A Other: 4 Nursing Home 5 Bc. Injury at Work? 1 Yes 2 No 7, office 28f. Loc Cit.	1 Yes 2 No 3 Probably 4 Unknown I.e. Wes an autopsy performed? 24b. Were autopsy finding aveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No extremely one) Residence 8 Other (Specify) I.e. Specifies how injury occurred Other (Street and Number or Rural Route Number, or Town, State) I.e. Other cause(s) and menner as stated.
Il director, page 2 should be detached for use a To Be Completed by Physician/M	Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying categories.	26. Place of Death (Check A Other: 4 Nursing Home 5 Sec. Injury at Work? 1 Yes 2 No No Notice 28f. Log Cit at the time, date end place, end due in my opinion, death occurred at the License number 5 6 6 4	1 Yes 2 No 3 Probably 4 Unkn e. Wes an autopsy performed? 24b. Were autopsy finding aveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No ck only one) Residence 8 Other (Specify) escribe how injury occurred cation (Street and Number or Rural Route Number, yor Town, State)

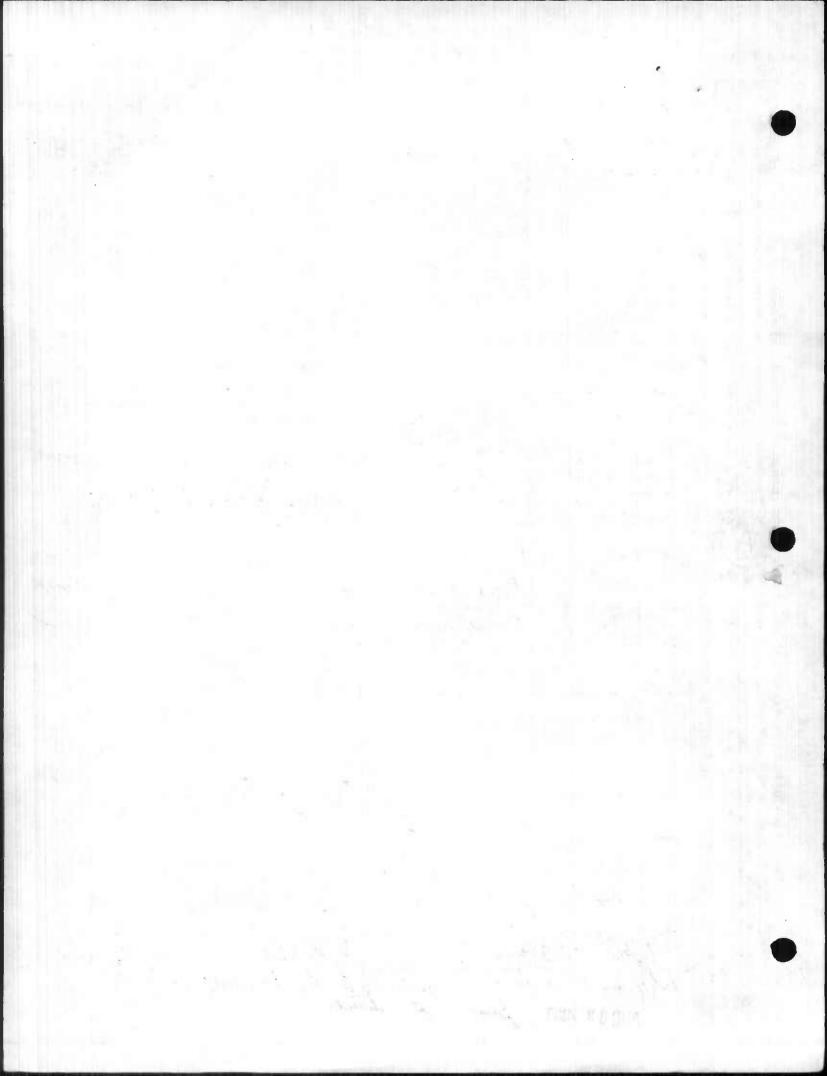
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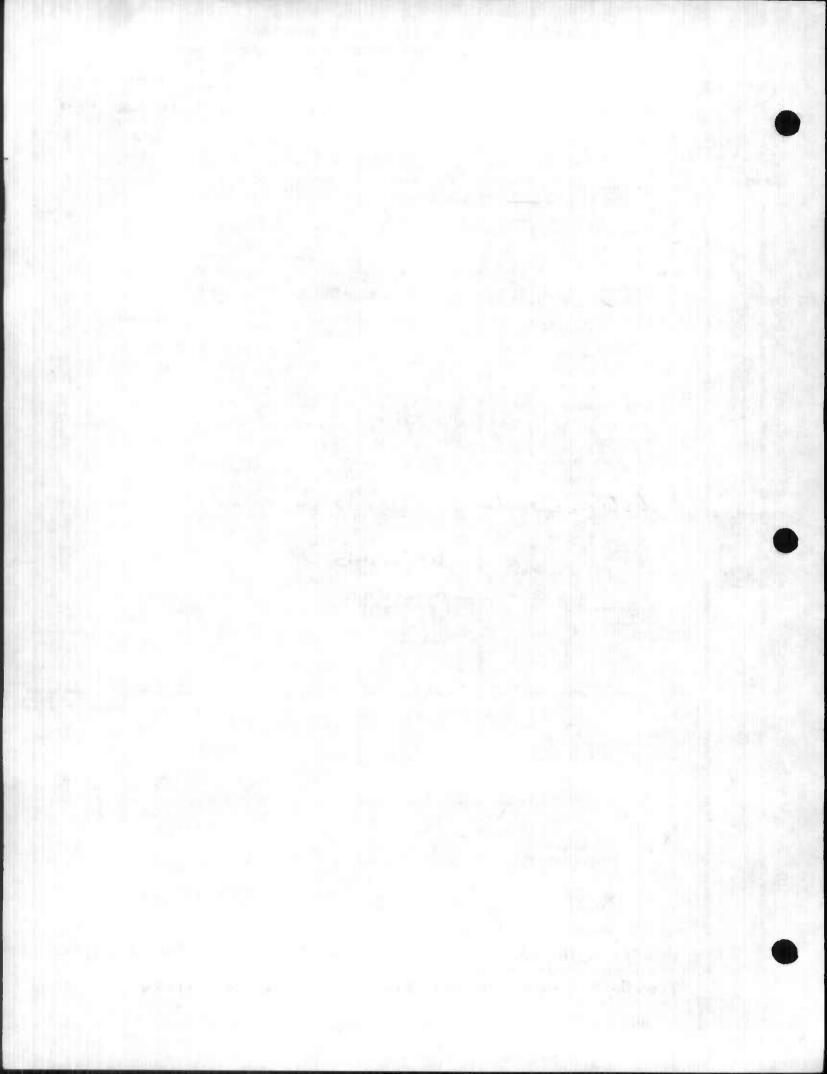
State of Maryland / Department of Health and Mental Hygiene Amend Items #27 thru 28f, per ME G786 8/23/00dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** CLIFFORD Lois .03 AM J444 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Livingston Health Care Center Fort Washington Prince Georges Co. If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Days 1 M 2 F Director 220-24-5002 70 Aug. 11,1929 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow r than "natural", or Name 23a or 28a-f ahor the Medical Examiner must be notified at Bryans Road Maryland Charles 1 ☐ Yes 2 No Director 10a Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 20616 7300 Carroll Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12. Was Deceden1 Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify à 3€Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years Sparmit. Pages 1 and 2 should be filled a Department of Health and Mental Hygie important: if Item 27 is marked other 1 ent injury or other traumstic avent, III prings. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Louise M. Brinkman Nicholas Lippert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryans Road, MD 20616 7300 Carroll Drive (Daughter) Faith Hennasey Baltlmore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥⊠Burial 2 ☐ Cremation 3 ☐ Removel from State 7/31/2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility ure of Funeral Service Line Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Dundalk, Maryland 23a. Part1. Enter the disease, or complications that council the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each ne. Approximate tnterval Between Onset and Death Phusician Immediate Cause (Final disease or condition resulting in death) Kulmonny /Nedical Evamilier Examiner CERTIFICATION APPROVED BY MEDICAL EXA lician and burlai-transit Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician a Box 68760 attending Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by 1 Yee 2 No 3 Probably 4 Unknown OSKIDENNE Records, à 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this After thi 27. Manner of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Tanatural 2 Accident 5 Pending i or Attending after deeth. Director: After Fe11 1 Yes 2 No investigation Unknown July 9,2000 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours aft To the Funerel Di completaly filled in 7300 Carroll Dr., Bryans Road, MD home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Tone address of person who completed cause of death (Item 23a) (Type, Print) 11701 Courselm R1. Ft. WASH 10nnc/m 32 Registrer's Signeture 31. Date filed (Month, Day, Year) State AUG 03 2000 Registrar



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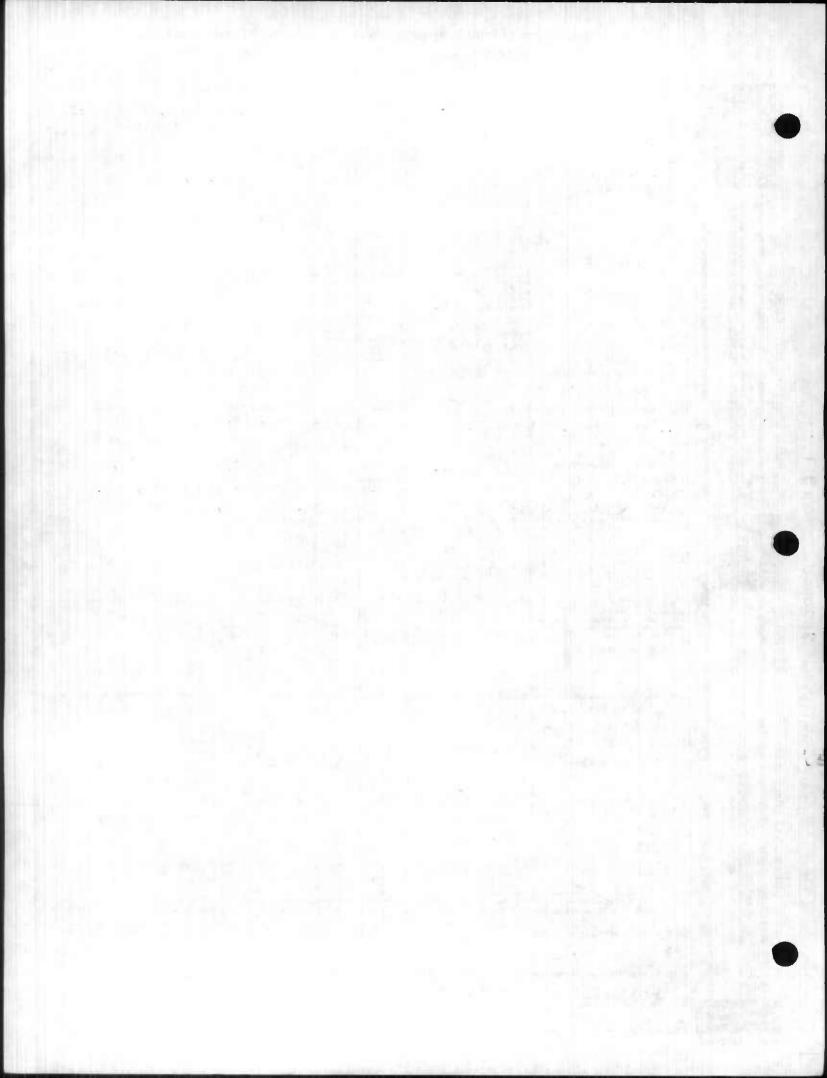
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An	1. Decedent's Neme (First, Middle, Las				2. Deta of Dea	th	3. Time of Death			
Physician	Carmine		(resta	A WAVIS		oar 0155			
/Medical	4a Fecility Nama (If not institution, giva	street and number)			or Location of Death	4c. County of	~			
Examiner				BaH	timore	more NA				
Firmula	5. Sociel Security Number 6. Se		st birthday) If Unde	r 1 Yaar If Under 24 H	rs. 8 Data of Birth		Birthplaca (Stete or Foreign Country)			
Funeral Director		XM 2□ F 76	Yrs. Months	Deys Hours M	in. (Month, Dey	16 19 B	WARY LAND			
	Usuel Residence of Decedent	Ralto			0-7-22-7	10,110				
ahow	10a. State 10b. County BB	Balato 10c. City,	Town or Location				10d. inside City Limits			
or 28e-f sho be notified Director	md Dunda	WBALTIMORE DIC	udalk				1 Yas 2 No			
r 28a-f	10e, Street and Number	400 100	10f. Zi	Code	1	0g. Citizen of Wh	at Country?			
Sa or	3415 CORNW	All Rd		31333		U.S.	A.			
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s4 show are I Escalant cast to notify a seed by Funeral Director	11. Merital Status	12. Wes Decedent Ever in U.S.	13. Wes Dece	dent of Hispanic Origin?	(Specify Yes or No-		American Indian,			
or he	1 Nevar Married 2 Married	Armed Forces? 1 12 Yes 2 □ No		cify Cuben, Mexican, Pu	arto Hican, etc.)		White, etc.			
020 urs by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Giva Yeer or Detes:	1 Li Yas	2 No Specify:		Specify:	Shite			
15-0020 72 hours aft natural; or	15. Decedent's Edi (Specify only highest gred	ucation	16a. Decedent's Usu	el Occupation ork done during most of v	working	16b. Kind of Busi	ness/Industry			
	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	ise retired)		(, ,				
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yland 21215-0 wid be lifed within 72 ho Mental Hygene. Treed other transment ritic event, me indical To Be Completed	17. Father's Name (First, Middle, Last)	,		18. Mother's N	Neme (First, Middle,	Meiden Sumame)				
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Maryland 2121 nd 2 should be lifed within this and Mariel Hydiene. T is marked other than retrainments event, the Maryland that I have been than To Be Comple	19e. Informent's Neme/Reletionship (7			s (Street end Number or	Rural Route Number	, City or Town, St				
e, M 1 and 1 Health em 27 Ither tr	YVONNE Shir	K (daughter)	3415 2	ORNWALL K	d Pundre	is mo	21222			
Baltimore, Maryland 212. permit. Pages 1 and 2 should be lifed withir Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any Injury or other traumatic event, the Mental. To Be Comp	20e. Method of Disposition	000	ca of Disposition (Ne netery, cremetory or	me of other plece)	Dete	20c. Location - Ci	ty or Town, State			
Page nent mt: If my o	1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specify		PO CREN	ATORY	8/23/200	(ATONS VI	WE MP			
Baltime permit. Pag Department Important: If any Injury o	21. Signeture of Funeral Service Licens	500	22. Name a	nd Address of Fecility						
Bal Departiment any Ir	1.11	1.11	CONN	sollers	41 Home	Dundal	21222			
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Physician	shock, or heart feilure. (1 st only o	one cause on each line.					Intervel Between Onset and Death			
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Examiner	diseese or condition resulting in deeth)		LVO Septer se e consequenca ot	-4-			1			
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execu	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury									
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68 tiffica	resulting in death) Last									
Box 6 sath certification of the sate of th	CHI IN COLUMN	d					1			
is, P.O. Box 6 set that the death certific gened by the attending to be detached for use as by Physician/Me	Pert tt. Other eignificant conditions co	entributing to death but not result	ing in the underlying	cause given in Pert I.	23b. Did t	obacco use contr	ribute to the cause of death?			
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T 00 ± 0						in autopsy	24b. Were autopsy findings available prior to			
w requ					_	MIQU'	completion of cause of death?			
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f Vital Riversity yelden: The la director, page	25. Was case referred to medical			26 Place of I	Deeth (Check only o	- '				
Of Vita Physician: this certificantal director.	evaminer?	Hospitel: 1 (Nonpatient 2 E	R/Outpetient 3 D	Othor	g Home 5 Resid		(Specify)			
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Division or Attending after death. Director: After in by the fune	3 ☐ Suicida 6 ☐ Could not be	200. Pieca of injury - At nom	e, ferm, street, facto	ry, offica			or Rurel Route Number,			
Diversity of Diver	4 Homicide	building, etc. (Specify)			City or Tow	n, Stete)				
epita nours neral fillo	29a. Certifier 1 Certifying Phy	vetclan: To the best of my knowl	edge, deeth occurred	et the time, date and ple	eca, end due to the	euse(s) end men	ner as stated.			
Division of Valential of Valential of Valential of Valential of Valential of Valential of Completely filled in by the funeral direction of Valential	(Check only 2 Medical Exam	iner: On the basis of exeminetic and mannar stated.	n and/or investigetlo	n, in my opinion, death o	ccurred at the time,	lete end piece, an	d due to the cause(s)			
Me Within	29b. Signeture end title of certifier		29	c. License number		29d. Date signed	(Month, Dey, Year)			
- 3 - 0	1. de	. 1		21013		August	1 21 2000			
10	30. Name and address of person whole	propleted cause of death (Item 5	(3a) (Type Print)			7.19	01, 200			
4)	T:	10.110 - 1	Ave	Bulding	D MA	21224				
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Signetu		Baltimor	0 110	21224				
Registrar	AUG 2 3 2000	Geneva	& los	1						



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Physician // Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) Concegio A. Celeste Concegio A. Celeste 2. Date of Death Month Day Year August 20, 2000 1:37 August 20, 2000 1:37 4c. County of Death Harford Memorial Hospital Funeral Director Funeral Director S. Social Security Number 6. Sex 117-20-2730 180 M 20 F 70 Yrs. 117-20-2730 180 M 20 F 70 Yrs. 117-20-2730 180 M 20 F 70 Yrs. 118 M 20 F 70 Yrs. 119 State 10b. County New York New Y	AM rd Foreign Limits
August 20, 2000 1:37	rd Foreign Limits
### Facility Name (If not institution, give street and number) Harford Memorial Hospital Second Security Number 17-20-2730 120 M 2 F 7. Age (In yrs. last birthday) 17-20-2730 120 M 2 F 7. Age (In yrs. last birthday) 180 M 2 F 7. Age (In yrs. last birthday) 190 Months	Foreign Limits
Funeral Director 5. Social Security Number 1.7 - 20 - 2730 180 M 2 F 70 70 70 70 70 70 70	Foreign Limits
117-20-2730 180 M 2 F 70 70 70 70 70 70 70	Limits
10a. State 10b. County 10c. City, Town or Location 10d. Inside City 1 Yes 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Goucher Way 21028 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16b. Kind of Business/Industry City of Baltimore	
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3 Widowed 4 Divorced Year or Dates: 1947-1951 1 Yes 2 No. Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 Years College (1-4or 5+) 12 Years Specify: Specify: White Specify:	
9 5 3365 0	
Francesco Celeste Assunta Valari	
17. Father's Name (First, Middle, Last) Francesco Celeste 18. Mother's Neme (First, Middle, Meiden Sumeme) Assunta Valari 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Many Delay in the Property of the Print of the	
Mrs. Patricia R. Celeste (Wife) 200 Goucher Way Churchville, MD 21028	m-
20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
20a. Method of Disposition **PXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 8/23/2000 Dundalk, Marylan 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.	nd
21. Summary uneral Service, Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.	
7922 Wise Ave. Dundalk, Maryland 21222	
23a. Parri. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval above. List only one cause on each line. Approximate interval above. Onset and Dr. Onset	
Physician /Medical Immediate Cause (Final III)	1
Tailure disease or condition resulting in death) a. Thit Urgan Tailure	eele
Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Eight Underlying	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
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25. Was case referred to medical examiner? 26. Place of Deeth (Check only one)	
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Netural S Pending Injury M 1 Yes 2 No Street and Number or Bural Boute Number Number of Bural Boute Numb	**
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29a. Certifier (Check only control of the cause (s) and manner as stated. 29a. Certifier (Check only control of the cause (s) and manner as stated. 29a. Certifier (Check only control of the cause (s) and manner as stated. 20 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause (s)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
1 19583 August 20, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Law Street & Spendeen	
MARNEL M- LAZTIV HD havyland 210	21
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar AUG 2 3 2000 Server & According to the state of the state	

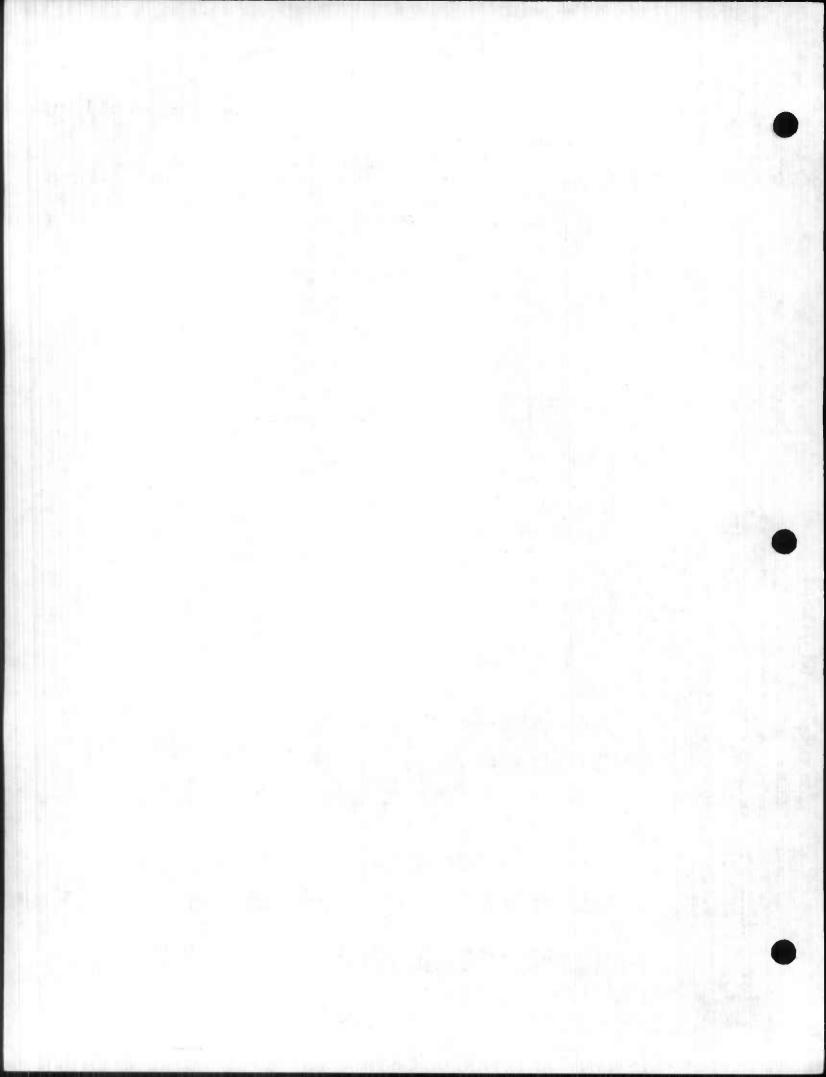
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State of Maryland / Department of Health and Mental Hygiene 00 266

	Certificate of Death	Reg. No.	10 50010
Physicia /Medica		2. Data of Death Month Day August 18	Yaar 3. Tima of Death
Examine	4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Lo		unty of Death
AC	ST. AGNES HOSPITAL BALTIMO 5 Social Security Number 6 Sex 7 Ans (in vrs. lest hirth/tax) If Under 1 Year If Under 24 Hrs.		/A
Funeral Director	5. Social Security Number 6. Sex 1 Months Days Hours Min. 233-54-1207 Usual Rasidence of Decedant	8. Data of Birth (Month, Day, Year) APR. 18, 19	9. Birthplaca (Stata or Fora Country) UNKNO
D Bu	10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limi
m the Maryla or 28a-f shor a notified at	MD BALTIMORE CATONSVILLE 10a. Streef and Number 10f. Zip Coda	10a Citizan	1 ☐ Yas 2√1 f
6 6 8	701 EDMONSON AVENUE 21228	U.S.	.A.
0020 ours after de mar, or Herre Examiner m	TOT EDMONSON AVENUE 21228	Rican, atc.)	Raca - Amaricen Indian, Black, Whita, atc.
Maryland 21215-0020 42 should be filed within 72 hours all th and Merital Hyglene. 7 is merited other than "natural", or traumetic event, the Medical Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) NONE 16a. Decedent's Usual Occupation (Give kind of work done during most of work) iffa. DO NOT use ratired) NONE		of Businass/Industry
nd 2	NONE	NON	
and see		a (First, Middla, Maidan Sun	
Irylar though by of Wester marked marke ev	(UNKNOWN) COHEN (UNKNOW		(UNKNOWN)
	19a. Informant's Name/Ratationship (Type, Print) CHARLES FISHER / GUARDIAN 19b. Meiling Addrass (Street end Number or Rura 611 CENTRAL AVENUE — T		
Baltimore, N semit. Pages 1 and Department of Health Important; if then 27 my Injury or other 1 000s.	20a. Mathod of Disposition 20b. Place of Disposition (Nema of cematary, cramatory or other place)		on - City or Town, State
Hin Py refund	4 Donation 5 Other (Specify) (ANSHE EMUNAH) AITZ CHAIM 21. Signature of Fureral Service Licensee 22. Name and Address of Facility	8/22/00 BAL	TIMORE, MD
De Department of the partment	8900 REISTERSTOWN R		N & BROS., INC.
Physician	23a. Part1. Enter the disable, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of shock, or heart feilure. List only one cause on each line.	or raspiretory arrest,	Approximate tntarval Batween Onset and Death
/Medical : Examiner	Immediate Causa (Final disaesa or condition rasulting in death) a. Alberto Sclerotsc Condition or as a consequence of):	culor Po	seuse 36 ye
68760, tificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last b. Dua fo (or as a consequence of):		
- 5 O 0		22h Did tahang ua	contributs to the cause of de
IS, P.O. BOX es that the death ce igned by the attendir be deteched for use	Mental Retordation		No 3 Probably 4 Unkr
Records, P.O le lew requires that the le has been signed by th tge 2 should be detech	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Men Lu (ReLanda + 10 m	24a. Was an autopsy performed?	24b. Wera autopsy findin available prior to complation of cause of deeth?
The lew ate has b page 2 s		1□Yas 2DN	lo 1 Yas 2 No
Vital Relocations The lever certificate has rector, page 2	25. Was case refarred to medical 26. Place of Death	h (Check only ons)	
0 0 0 m	Hospital:	oma 5 Rasidence 6	Othar (Specify)
ding Ph After th funeral		28d. Dascribe how Injury or	ccurred
Division or Attending after death. Director: After d in by the fune	2 Accident Accident Accident Accident Accident Accident 3 Suicide 5 Could not be datarmined 4 Homicida Accident		lumber or Rural Routs Number,
Div ors after oral Dire	building, afc. (Specify)	City or Town, Stata)	
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 28a. Data of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yas 2 No 28a. Place of Injury - At homa, farm, streat, factory, offica 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, daeth occurred at the time, deta end place, end menner steled. 29b. Signatura and office of the property of the passe of exemination and office of the property of the passe of exemination and office of the property of the passe of exemination and office of the property of the property of the passe of exemination and office of the property of the passe of exemination and office of the property of the proper	red at the time, data end pta	ace, and due to the cause(s)
T V V V V V V V V V V V V V V V V V V V	De glenberg 1 27315	- Pugu	igned (Month, Day, Year) 1 1 / 200 Lul, Bellius
	30. Name and address of person who completed cause of death (Nem/23a) (Type, Print) MCFry Ven Dorg MN) St. A una	25 Hospro	tal, Beldino
State Registra	ALLO O 9 2000 King and M	V	100



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth 9:02am ISABELLA M. D'ANDREA 22nd 2000 Llua 4b. City, Town, or Location of Death 4e Fecility Nama (If not institution, giva straat and number) 4c. County of Death HARFORD HEALTH - BETAIR MARINER If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 6 Sax 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 913 9. Birthpiece (State or Foreign Country), NEW YORK 1□ M 2♥ F Months Deys Hours 86 095-12-0871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b County 1 Yas 2 No Maryland Harford Edgewood 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? U.S.A. 602 Banyon Court 21040 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Bace - American Indian 11. Merital Status Black, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 🕱 No Specify: White 3 X Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 8th grade Own Home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) William Murphy Maude McKinley 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara D'Andrea (Daughter) 1100 C. Iron Bark Court, Bel Air, MD 21015 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donetion 5 Othar (Specify) Highview Memorial Gardens 8/25/00 Fallston, Maryland 22. Nama and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 21. Signeture of Funeral Service Licensee Mark T. Z 23e. Part1. Enter the diseas and my lications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Obstructive Pulminary Disect Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contributa to the cause of death? Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 MYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to complation of causa of death? 24e. Wes en eutopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 28. Plece of Deeth (Check only one) exeminer? Other: Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Invastigation Injury Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

D'Andred ds, P.O. Box 68760, ISa bella

death. i or Attend after death Director: To the Hospital of within 24 hours a

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Medical Examinar main to notified at

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples.

Physician

/Medical

Examiner

physician end s the bunel-tran

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hes page 2

After this certificate

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funeral

completely filled in by

Examiner

Physician/Medical

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2

Certification:

Medical

29b. Signeture end title of dentile

31. Dete filed (Month, Day, Year) AUG 2 3 2000

Baltimore, Maryland 21215-0020

the Marylend

deeth

State Registrar

DHMH 16 Rev 6/95

29c. Licanse number 034652 29d. Data signed (Month, Day, Year)

30. Neme, end eddrass of person who completed cause of deeth (Item 23e) (Type, Print) Haswill

North ANGUL 0 32. Registraris Signeture

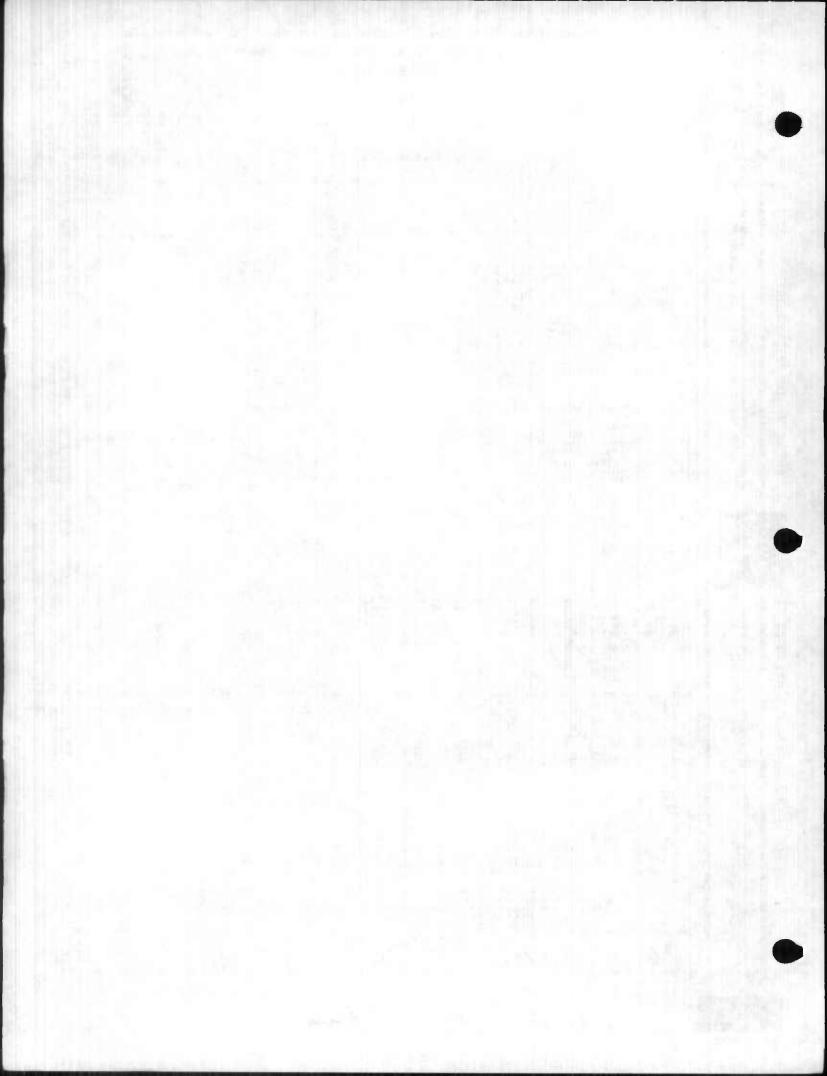
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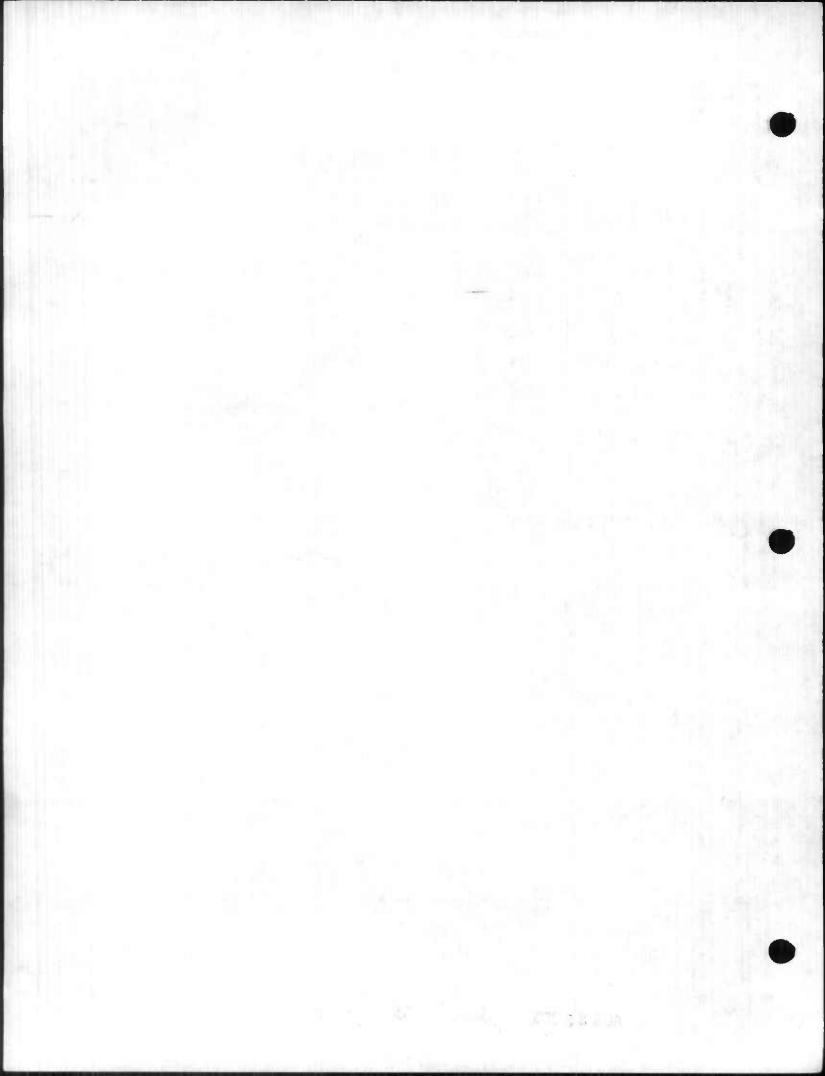
State of Maryland / Department of Health and Mental Hygiene 00 26612

					Certi	ificate of	Death			Reg. No.		
		1. Decedent's Name (First, Middle, La	est)						2. Date of Dea		V	3. Time of Death
	Physician	Agnes Theresa 1	Delaforce						Month 08	19° 20	OO	9:47 AM
	/Medical Examiner	4e Facility Name (If not institution, give	ve street and numb	er)			4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	
- 4	Examine	5782 Main St	reet.				Elk	rid	qe	Howa	rd	
-	Funeral	5. Social Security Number 6. 5	Sex 7.	Age (In yrs. last bil		If Under 1 Year			8. Date of Birt	h .	9. Birth	piace (State or Foreign
	Director	215.10.1970	1□M 2√F	89	Yrs.	Months Days	Hours	Min.	(Month, Da)	.1911	E1k	place (State or Foreign ntry) Cridge, MD
	70	Usual Residence of Decedent										
	ylan M M	10a. State 10b. County		10c. City, Tow		afion					1	10d. fnside City Limits
	Mar Ind	Md Howard		Elkri	dge							1 ☐ Yes 2 ☐ No
	or 25e4 s be notified Director	10e. Streef and Number				10f. Zip Code				10g. Citizen of V	What Cou	ntry?
	oath with the Maryla to 23s or 28s-f sho mast be notified at eral Director	5782 Main Stre	et.			210	75			USA		
	Joett Ing	11. Merital Stetus	12. Wes Decede		13. Wa	as Decedent of I Yes, specify Cub	Hispanic Ori	gin? (Sp	ecify Yes or No-	14. Rac		can Indian,
-	五 新 五	1 Never Married 2 Married	Armed Force		If Y	Yes, specify Cub	oan, Mexicar	n, Puerto	Rican, etc.)	Blac	ck, Whife,	etc.
020	by Chi	3℃Widowed 4 □ Divorced	If Yes, Give Year or Date		10	☐Yes 2 No	Specify:			Specify	· Wh	nite
21215-0020	pa page	15. Decedent's E	ducation	16a	. Deceder	nt's Usual Occu	pation			16b. Kind of Bu	usiness/In	dustry
15	And And	(Specify only highest gr			(Give kir life. DC	nd of work done NOT use retire	during mos	t of work	ing			
212	od within vigene.	Elementary/Secondary (0-12)	College (1-4	or 5+)		rvisor				Reta	il	
D		1 () 17. Father's Name (First, Middle, Last	")				18. Mothe	er's Nem	e (First, Middle,	Meiden Sumam	10)	
lan	d bed of the first	Frank Joseph	Petrlik				The	res	a Sima			
7	d Men d Men merks mette	19a. Informant's Name/Relationship			h Meiling	Address (Stree	t and Numbe	er or Rur	al Route Numbe	or, City or Town,	State Zir	n Code)
Ma	0 2 ac 7 th ac	Mary Petrlik-			-							re, Md2122
6	Tan Tan	20a. Method of Disposition	010001	20b. Placa o	of Disposit	tion (Neme of			Defe	20c. Location ·		
more	and	1 ☐ Burial 2 ☐ Cremation 3 ☐		cemete	ery, crema	tory or other ple		0 8	/22/00			lle, MD
tin	time dury	4 Donation 5 Other (Special		chesa		ke Cre		- 1				
Sal	e par my in	21. Signature of Funeral Service Lice	nsee	01	Ga I	Name and Addr L.	ess of Facilit Kaufm	ian	Fun'1	Hm.@Me	ador	wridge Mem
-	40540	1/1107 (.71)	Cusha	XP		_						dge, Md210
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cau	sed the death. Do	not enter	the mode of dy	ing, such es	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician							1			1	Onsef and Deeth
	/Medical	Immediate Cause (Final disease or condition	Ca	Due to (or as a	2 /	1000	7	20	100	1		
	Examiner	resulting in death)	a	Due to for as a	conseque	ence_of):	, .	^				
	Je L	ESTATE OF A DE	27	noal	1.	00	1 1					
	axecuted n and ial-transit	Conventially list conditions	b	Due to (or es e	conseque	ence of):	al	1				
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68760,	certificate be assecuted rding physician and use as the burial-transit as the deficial Examir	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or as a	conseque	ence of):						
89	ding physe as th	resulting in death) Last		200 10 (0. 00 0	oonsoque	3,100 01).						
X	nding use s		d	^								
Bo	at the death of a by the attend etached for us	Det II Other elections and them.		-	in the cond	ladda anna a	i ion in Don't		22h Did	obacco uno co	ntribute (to the cause of death?
0	ed by the detached	Part II. Other significant conditions of	ontributing to deat	n put not resulting t		The land	20 CA			V	3 □ Pro	
0	C X 79	Dronce	lua	1 a	1)	114	run		10	Yea 2 No	3 L Pro	bably 4 Unknown
ds,		a not			11				24a Was	an autopsy	24b. W	Vere autopsy findings
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lec	hes by 2 a 2 a mpi									4.4	ol	death?
	The late he page								10	res 20 No	1	☐ Yes 2☐ No
Vital	certificate rector, par	25. Wes case referred to medical examiner?					26. Place	e of Deat	th (Check only o	ne)		
>	5 0 0 0	1 Yes 2 No	Hospital: 1 Inp	atient 2 ER/O	utpatient	3 DOA O	ther: 4 No	ursing Ho	ome 5 Resid	denca 6 Oth	er (Speci	ity)
of	erth leral	27. Manper of Death	28a. Dete of I (Month,	Injury 28b.	Time of Injury	28c. fnju Wo	ury at		28d. Describe	now injury occur	red	
0	ath. Ath	1 Natural 5 Pending investigation		Day rosi,	прогу		Yes 2	No				
Division	Attending or death. octor: After by the fune fune fune fune fune fune fune fun	3 Suicide 6 Could not be determined	280. Placa of	Injury At home, for	arm, stree	et, fectory, office			28f. Location (per or Rur	ral Route Number,
ā	tal or Attending P is after death. In Director: After the ed in by the funer. Certification:	4 D Homicide	building,	, etc. (Specify)					City of Tol	VII, State)		
	Hospital 24 hours Funeral Mely filled		nysician: To the be									
	he Hospit in 24 hour he Funer pletely fill	(Check only 2 Medicat Examone)	miner: On the basis and manner	s of examinetion ar stated.	nd/or inve	stigation, in my	opinion, dee	th occur	red at the time,	date and place,	and due t	to the cause(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29b. Signeture and title of certifier	,	20	12.1	29c. Licen	se number	1.		29d. Dafe signe	d (Month	, Day, Year)
	PSFO	DA (1 pm	0./1	PICOL	101,	. D(701	4.	79X	8.	9	1.00
	11)	in see	MI	/	N	17	01-	1 1	10	10	4	, 00
1	Me	30. Name and address of person who				rint)	116	N	AIDE	N CI	4010	E Lane
	M)	H-SHAMS		ZADE	14.	u.0),	7:	300	lion	MX		
	State	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signeture	Le	1	1					



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An		12 per FH G786 8—24—00		ertificate of Dea	th	Reg. No.	26613
L	Physician /Medical	1. Decedent's Nama (First, Middle, Lest) Yvonne		Everson	2. Date of De Month Augus	Day 20	3. Tima of Death
	Examiner Funeral Director	4a Facility Name (# not institution, give street and nu Sing 1 Hospital of 5. Social Security Number 6. Sex 1 M 2 M F	Baltimon 7. Age (In yrs. last birthda 44 Yrs.	Ba		rth 9	Birthplace (State or Foreign Country) M • D •
	pu ***	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	ath with the Meryland 23a or 28a-f show ant be notified at ral Director	MD NA	Baltimo	ore			1 Yes 2 19 N o
	with the Mela or 28e-f at the notined	10e. Street and Number	Dazez	10f. Zip Code	I	10g. Citizen of Wha	it Country?
	3a o	4205 Belvieu Ave		21215		U.S.	Α.
020	or hems	11. Maritel Stetus 12. Was Dec Armed Fe	ve Ale	3. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes XXNo Specify Cuban		14. Race - Black, 1 Specify:	Americen Indian, White, etc. Black
21215-0020	72		(Gi 1-4or 5+)	cedent's Usual Occupation ve kind of work done during . DO NOT use retired)	most of working	16b. Kind of Busin	
	GIES D	12th grade na 17. Father's Name (First, Middle, Last)	1 01	nemployed 18. M	lother's Name (First, Middle		Oyeu
Maryland	To be de Cm	Herbert Lee Everson		E	louise Jon	es	
any	N Dud N	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street and No	umber or Rural Route Numb	per, City or Town, Ste	ite, Zip Code)
-	Health e am 27 is wher tra	Elouise Everson-Mothe	er 420	05 Belvieu	Ave, Balti	more Md	21215
ore	00- 2/1/	20a. Method of Disposition XXBurial 2 □ Cremetion 3 □ Removel from	cemetery c	position (Name of rematory or other place)	Date	20c. Location - Cit	y or Town, State
Ē	Peg nent nent nent nent nent	4 Donation 5 Other (Specify)	Garris	on Forest V	et.8/23/00	Owings	Mills, Md
Baltimore	permit. Page Department of Important: If any Injury or page.	21. Signature of Funerel Service Licensee		22. Name end Address of F March F/H W 4300 Wabash	est	imore Md	21215
	Physician	23a. Part1. Enter the disease, or complications that shock, or heart dilure. List only one cause on	ceused the death. Do not e	enter the mode of dying, such	h as cerdiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	te Pontine Due to (or as a cont	And Left Co	erebral He	morrhag	e 2 Days
0,	cete be executed physician and s the bunial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Due to (or as e cons	Hypertensi	0n		
Box 68760,	at the death certificate be d by the attending physicial etached for use as the bur Physician/Medical	cause (cleases of injury that initiated events resulting in death) Last	Due to (or as e cons	equence of):	4 8	3.5	
. 0	the attented for hed for ysicial	Part II. Other eignificant conditions contributing to d	leath but not resulting in the	underlying cause given in F	Part I. 23b. Did	tobacco use contri	bute to the cause of death?
s, P.O	= 90 >	Bipolar Disorde			1	Yee 280 No 3	☐ Probably 4 ☐ Unknown
Records,	sw requires to should be should bleted					s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
E =	The laste has pege				10	Yes 2 No	1 ☐ Yes 2 No
Vital	certificate rector, peg	25. Was cese referred to medical axaminer?			Place of Death (Check only	one)	
of	7 0 D		Inpatient 2 ER/Outpat		☐ Nursing Home 5☐ Res		(Specify)
Division	tal or Attanding P is after death. al Director: After t led in by the funer: Certification:	2 Accident investigation	of Injury oth, Day Year) 28b. Time Injury		2 🗆 No	how injury occurred	
Divi	tal or Attandi is after death al Director: A led in by the f	determined 200. Flack	e of Injury - At home, farm, ling, etc. (Specify)	street, factory, office	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	Hospi 4 hour Funer tely fil			investigation, in my opinion,	death occurred at the time	, date and place, and	due to the cause(s)
	To the comple	29b. Signature and title of certifier	4. 0	29c. License num	Der C	29d. Date signed (Month, Day, Year)
		Acland nowood	M, D	RES	000	August	19,2000
	()	Helen Z. Norwo	se of death (Item 23a) (Typ	2401 Wes	+ BelvedeA	Avenue	Baltimore, MD
	State Registrar	AUG 2 3 2000	Bens /	9. sports			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26614

			Ce	rtificate	of E	eath		Reg	g. No.			
	1. Decedant'a Nama (First, Middla, Las	0						ta of Death	Day	Vana	3. Time of De	ath
Physician (Modical	NAME OF TAXABLE	Eleanor A	nn Ecke	er			1 -	onth gust	18 20	Year OOO	12:15	P.M
/Medical Examiner	4a Facility Nama (If not institution, give	street and number)			4t	. City, Town	, or Location	-	4c. County			
	307 Haile Ave	nue				Balt:	imore		Anne	Aru	inde1	
uneral rector	5. Social Security Number 6. Security Number 216 28 2133	7. Aga (In yrs	. last birthday) Yrs.	ff Under 1 Months	Yaar Days	If Under 24 Hours	Min. (M	ta of Birth onth, Day,) y 12,	(ear) 1933		laca (Stata or F try) cyland	oreign
	Usual Residence of Decedant			1 1								
terns 23s or 28s-t show her must be notified at furneral Director	10a. Stata 10b. County Maryland Anne Al		ity, Town or Lo							1	0d. Inside City I	
be notified Director	10e. Street and Number 307 Haile Avenue			10f. Zip (Code 21225			109	g. Citizan of W		try?	
ount oral			10 40				-0.10it.V	No			an Indian,	
Examile by F	11. Marital Status 1 Nevar Married 2 Married 3XX Widowed 4 Divorced	12. Was Decedent Evar in the Armed Forcas? 1 ☐ Yas 2 ☒ No if Yas, Giva Yaar or Datas:		Was Decede If Yas, specif	fy Cubar	Specify:	n? (Specify Y Puarto Ricen,	atc.)		k, Whita,		
ated bette	15. Decedant's Ed (Specify only highast grad	ucetion da completed)	16a. Dece	dent's Usual kind of work DO NOT use	Occupa k dona di	tion urina most o	ł workina	16	6b. Kind of Bu	sinass/Inc	dustry	
t, the Medical	Elamentary/Secondary (0-12) 6th	Collega (1-4or 5+)		nemake:		sing moor o			Own	Home		
	17. Fathar's Nama (First, Middla, Last)					18. Mothar's	Nama (First	, Middla, Ma	aidan Sumami			
affic ever To Be	E	dward Joseph	Bathon				Josep	hine S	Sanders	5		
27 is main r trauma	19a. Informant's Name/Ralationship (7 Josephine Ecker			ng Addrass Raven				_	City or Town, Ohio	Stata, Zip	Coda)	
t: If Nam 27 y or other to	20a. Mathod of Disposition 1 🗷 Burial 2 🗀 Cramation 3 🗀 4 🗀 Donation 5 🗀 Othar (Specify	Domesial from State	Place of Dispo camatary, cra	matory or oth	har place		Date: k 8/21		oc. Location -		wn, Stata	Land
importar any inju	21. Signature of Funaral Sarvice Licen		1 2	2. Nama and	d Addras	s of Facility	Gon	ce Fu	neral H			
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sician edical miner	Immediata Causa (Final disaasa or condition rasulting in daath)	· M	letas	state	c	Lur	9 (unio			6 men	11
<u> </u>		Dua to	(or as a conse	quence of):			,			1		
burial-transit	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause, (Disease or Injury that initiated avants	Dua to	or as a conse	quance of):								
ding physician and sa as the burial-transit Medical Examir	that initiated avants rasulting in death) Last	Dua to (or as a consec	quance of):								
for u												1,111
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shoui							2	4a. Was an perform		av	ara autopsy find ailable prior to implation of cau death?	
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certificate rector, pag	25. Was casa ratarred to medical					26. Placa o	of Death (Che	ck only ona)			
00	axaminar?	Hospital: 1 Inpatiant 2	☐ ER/Outpatie	nt 3 DO	A Otha	r: 4 🗆 Nurs	ing Homa	Rasidar	nce 8 Oth	ar (Specil	y)	
ctor: After this y the funerel di	27. Manner of Death 1 Natural 5 Panding 2 Accidant Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima o Injury	of 26	8c. Injury Work	at ? /as 2 No		Dascribe hov	w Injury occurr	ed		
To the Funeral Director: After th completely filled in by the funeral Medical Certification;	3 Suicida 6 Could not be data mined		homa, farm, st	traat, factory,	, office			ocation (Stri lity or Town,		er or Run	al Routa Numbe	er,
To the Funeral completely filled Medical C	29a. Cartifiar (Check only one) 1 Certifying Physics Cartifian 2 Medical Exam	rafcian: To the best of my kn finer: On the basis of examin and mannar stated.	owledga, daat ation and/or in	th occurred anvastigation,	at tha tim In my op	a, data and inlon, daath	place, and di occurred at	ua to tha cai tha tima, da	usa(s) and ma ta and place, t	nnar as s and dua t	tated. o tha cause(s)	
Toth	29b. Signatura and titla of certifier	^		29c.	. Licansa			29	d. Data signe		1	
En	▶ 24 lh) m			D	408	54			8118	ali	
JA.	30. Nama and addrased person who o	completed ceusa of daath (Ite	23a) (Typa,	Print)	Pal	81	Bal	timere	MD	21	202	
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	natura		,	40						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26615 Amend Item Part II, per ME, G786,8/23/00dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** WILLIAM **EDWARDS** D 4b. City, Town, or Location of Death 2000 1:10 am 6 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical System Baltimore N/A If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1X) M 2 F 220-14-2570 74 Director 4-18-26 Maryland **Usual Residence of Decedent** death with the Menyland 10a State 10b County 10c. City, Town or Location 10d Inside City Limits ahow Md. N/A Baltimore 1X Yes 2 No Director 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 U.S.A. 601 South Street Funeral or Nerna 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0020 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Depmit. Pages 1 and 2 should be filed to be sufficient of Heelth and Mental Hygies Important: If hem 27 is marked other the any injury or other treumatic avent, the page. Uknown Unknown 8th Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) unknown Rose Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Brown- Sister 2535 West Pratt St. Baltimore, Maryland 2122: 20b. Place of Disposition (Neme of cametery, crametory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 5-15-2000 Metro Crematory Maryland 4 Donation Other (Specify) 21. Signature of Fu oral Se 22. Name end Address of Fecility VIIIler funeral Home Teller are complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Cardiac Dysrhythimia disease or condition resulting in death) Examiner Due to (or as e consequence of): Aterial Sclertic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Mycardial Infarction Physician/Medical Due to (or as a consequence of) Hypertension Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, à 24b. Ware autopsy lindings eveilable prior to Completed 24e. Wes an autopsy completion of cause of death? certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Division of Vital Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2□ No Certification: To 1 Inpatient 2 TER/Outpatient 3 DOA 100 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Q Naturat 1 Yes 2 No 2 Accident after death Director: J 3 in by the 1 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of o 29c. License number 29d. Dete signed (Month, Dey, Year) 005 mo to completed cause of death (Item 23a) (Type, Print) Flociare mo Von 22 South Greene St., Baltimore, MD 21201 los

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State

Registrar

31. Date filed (M

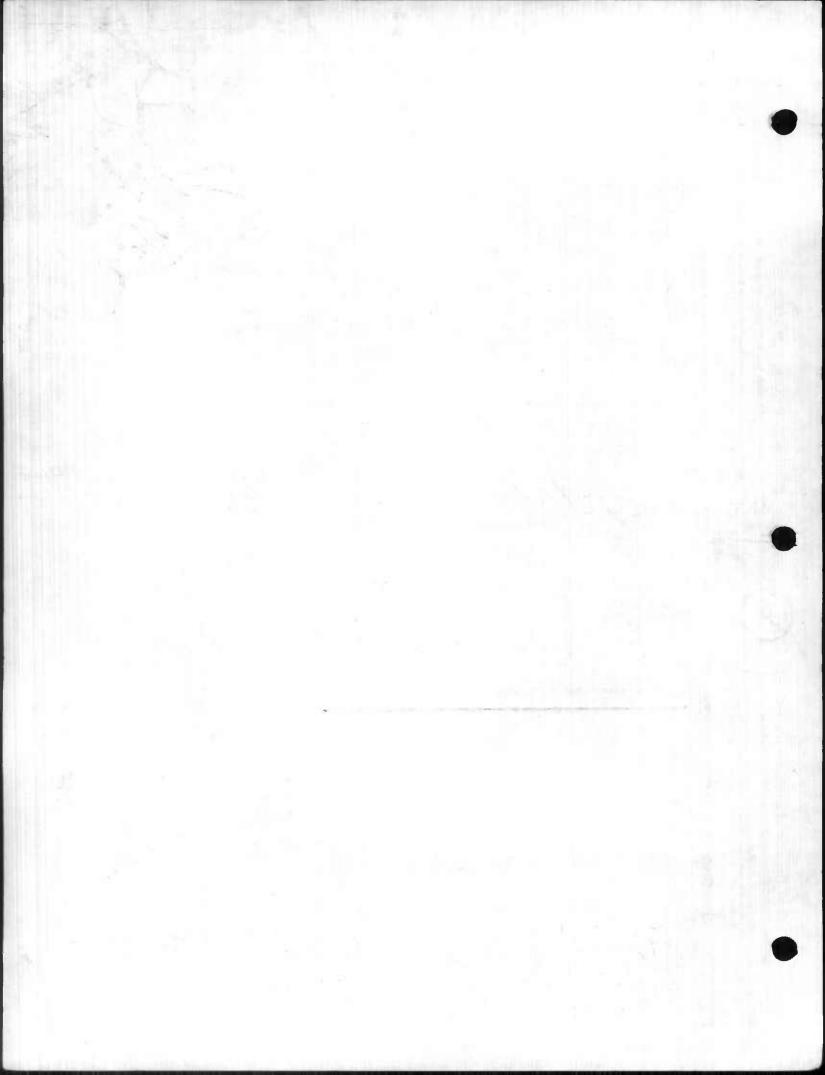
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32. Registrar's Signature

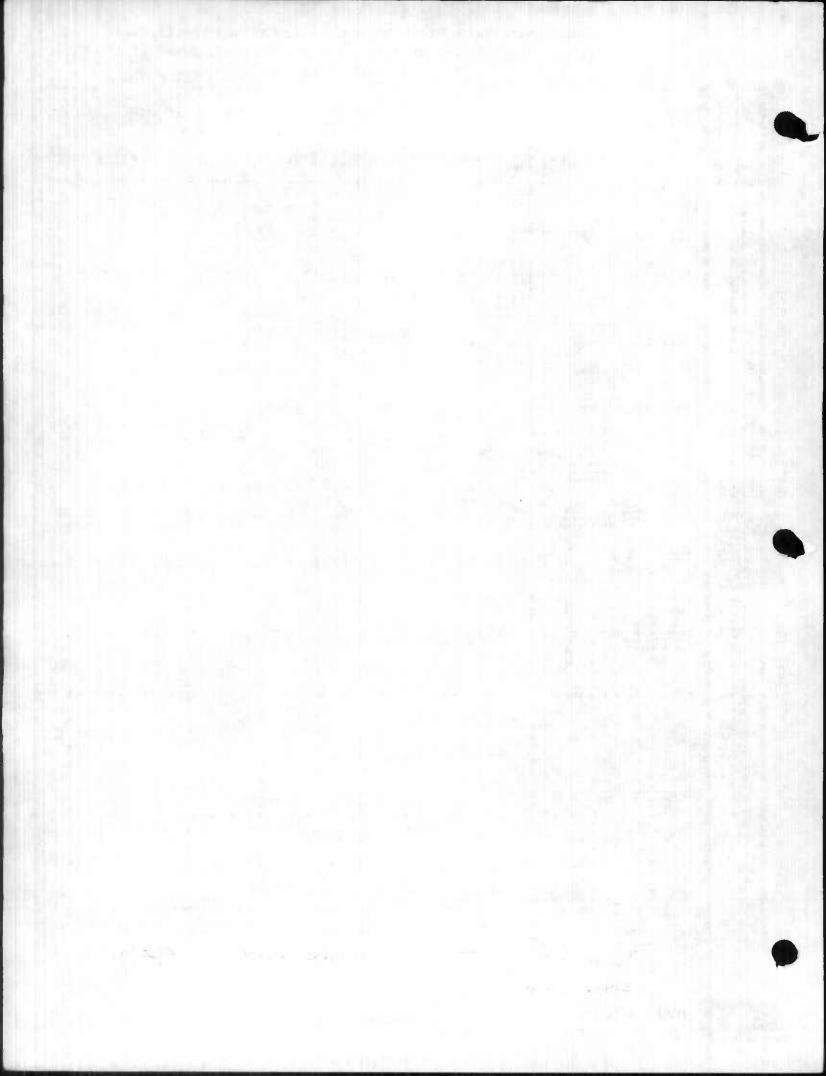
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State of Maryland / Department of Health and Mental Hygiene 00 26616

			Ce	rtificat	e of	Death		Reg. No.		20010
Block Co.	1. Decedent's Name (First, Middle, Las	1)		1	1		2. Date of D		Vees	3. Time of Death
Physician	Annie,		Edu	Va. A	/		Month	1 20 2	Year	130 Am
/Medical	4a Facility Name (If not institution, give	street and number	1.10	00/0		4b. City, Town,	or Location of Dee			Arri
Examiner Funeral Director	University 5. Social Security Number 8. Se	and Medi	rs. lest birthday)	If Under Months	5 1 Year Days	If Under 24 h	lin. (Month, D	N/ rth ay, Year) 1 22 1945	9. Birthpi Coun	lace (State or Foreig try) RYLAND
	Usual Residence of Decedent			-		-	AUGUSI	22 1740	FIEL	KIDAND
the Maryland 28s-1 show coffice	10a. State 10b. County	10c.	City, Town or Lo	ocation					10	Od. Inside City Limite
Man	MARYLAND N/A		BALTI	MORE						tXXYes 2 □ No
vith the Mary or 28e-f st be notified Director	10e. Street and Number	1		10f. Zir	Code			10g. Citizen of V	Vhat Coun	try?
\$ 5 Z Z										
death w	8 CHARLES PLAZA	APT 1907 12. Was Decedent Ever in	110 12		2120		(Specify Ves or N	U.S.A.	- America	an Indian
urs after	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	Armed Forces? 1 Yes 2% No if Yes, Give Yeer or Dates:		If Yes, spe		Specify:	(Specify Yes or Ni Jerto Rican, etc.)	Specify	k, White,	etc.
1 21215-UU: ed within 72 hours ygiene. Ar then "neturel; It, the Uddeller Completed by	15. Decedent's Edu	ucation	16a. Dece	dent'a Usu	al Occup	ation		16b. Kind of Bu	siness/Ind	lustry
plei	(Specify only highest grad		(Give	DO NOT	ork done ise retire	during most of	working			
within Jiene.	Elementery/Secondary (0-12) 12th grade	College (1-4or 5+)	DOMES	STICE	ENG	INEER		CHI	MES	
other sant, 18	17. Father's Neme (First, Middle, Last)		1001120				Name (First, Middle	e, Maiden Sumam	e)	
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Tylar hould be marked maric av			405 44 70	A 1.4	- (0)				Otete Tie	Cardal
Maryland 2 should be filed th and Mentel Hyg 7 is marked othe traumatic avant, To Be C	19a. Informant's Name/Relationship (T	ype, Print)					Rural Route Numi			
2 2 2 2	Charles Edwards,					aza Apt	1907, Ba			
ges 1 en t of Heal if Nem 2 or other	20a. Method of Disposition 1 Xiburial 2 Cremation 3 1		. Placa of Dispo cemetery, cre	matory or	me or other ple	ce)	Dete	20c. Location -	City or To	wn, State
L. Peges ment of ment of ment of ment of	4 Donetion 5 Other (Specify,		EDAR HI	TLL CI	EMETI	ERY	8-25-00	BALTIMO	RE.	MARYLAND
pemit. Peges 1 of Department of He important: If them any injury or other ones.	25 Septature of Funeral Service License		2:	2. Name e	nd Addre	ss of Fecility	COMMUNITY			
	23a. Part1. Enter the disease or comp shock, or heart failure. List only of	lications that caused the de				RTH_AVE		arrest,		Approximate interval Between
octificate be executed xing physicien and use as the buriel-transit and whether the control of t	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that inflated eventa resulting in deeth) Last	b. Mer for Due to	o (or as a conse	quenca of)						
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hat the death of the by the attend detached for us	Tartii. Other significant conditions co	titilibuting to death but not i	estiming in the t	or identifing	cause gi	out in Perci.		Yes 2 300		bably 4 Unknow
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required should should						340		s an autopsy formed?	av.	ere autopsy findinga ailable prior to mpletion of cause death?
The lev page 2							1	Yea 2000	1.5	Yes 2□ No
ficat T	25. Wes case referred to medical					00 Disease4				2010
certificate irector, pag	axaminer?	Hospitel:	Періс		Oti	nor:	Deeth (Check only		10	
and Physical distributions of the Total distributions of the Total distribution of the Total dis	27. Menner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of injury		28c. Inju Wo	4 LI NUISII	28d. Describe	e how injury occur		γ)
To the Hospital or Attending P within 24 hours feller death. To the Funeral Director Affert completely filled in by the Linear Medical Certification:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		treet, facto			28f. Location City or To	(Street and Numb own, State)	er or Aure	I Route Number,
the Hospital hin 24 hours the Funeral appletely filled		sician: To the best of my liner: On the basis of examend manner stated.								
To the	29b. Signeture end title of certifier			29	c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
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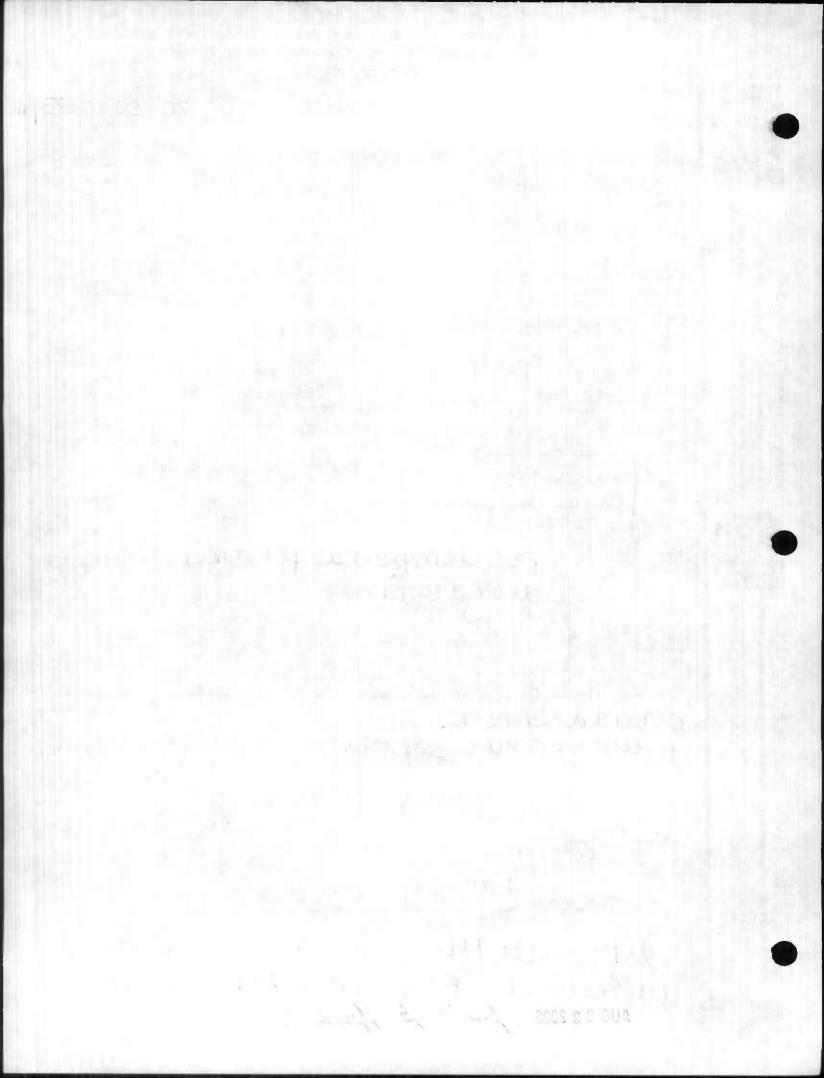


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State of Maryland / Department of Health and Mental Hygiene

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	-001

			Certificate of	Death	R	eg. No.		-0011
	1. Decedent's Name (First, Middle, Last)		C. E. C. C. Sup	Market H	2. Date of Deat		Vaca	3. Time of Death
Physician	Gloria		Gi	les	Month	20	Year	75500
/Medical Examiner	4a Fecility Name (If not institution, give street at	nd number)	0,1	4b. City, Town, or L	ocation of Death	4c. County	of Death	1001
Laminer			761	Pikesvi	110	Balti	moro	
E	7903 Brookford Cir 5. Social Security Number 6. Sex	7. Age (in yrs. last birtho	dev) If Under 1 Yee	If Under 24 Hrs.	8. Date of Birth (Month, Dey,	Daili		
Funeral	1 □ M 25		Months Devs	Hours Min.				ace (State or Foreign
Director	228-32-2147 Usual Residence of Decedent	/1			07 0	2 29	V.	Α.
F 1.	10a. State 10b. County	10c. City, Town o	or Location				10	d. Inside City Limits
A Pary	MD Daltinana	Dile						1 ☐ Yes 2√ No
uith the Ma or 28s4 s be notified	MD Baltimore	PIKE	sville		1	0g. Citizen of V	What Count	n.2
						og. Onzen or v	THE COOK	Ty I
6 2 4 5	7903 Brookford Cir			1208			S.A.	
her death v theme 23s siner must	Arm		 Was Decedent of if Yes, specify Cul 	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		e - America ck, White, e	
00 mg	1 Never Merried 27 Merried 1 If Ye	Yes 2 No	1□ Yes XXNo	Specify:		Specify	<i>'</i> :	
21215-0020 1 within 72 hours a piers. The Medical Exam Completed by	3 ☐ Widowed 4 ☐ Divorced Yea	r or Dates:					Bla	ck
1 21215-0 ad within 72 ho ygiene. wer than "nature 4, the Medical.	15. Decedent's Education (Specify only highest grade complete and a second seco	16a. D	ecedent's Usual Occu	pation during most of work	kina	16b. Kind of Bu	siness/Indi	ustry
21 mm 21		ege (1-4or 5+)	Give kind of work done if a. DO NOT use retire	9d)				
12 Maria	12th grade 2 v	rs	Homemak	er		H	ome	
D dung	17. Fether's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I	Maiden Sumem	Θ)	
Vlar Mentalities Mentalities To E	Roosevelt Curtis			Josephi	ne Russ	sell		
Maryland of a should be file the and Mental Hy 7 is marked other traumatic event	19e. Informant's Neme/Relationship (Type, Prin	t) 19b. A	Mailing Address (Stree				Stete, Zip	Code) 21208
M dd 2	Alexander Giles-Hu	ighand 79	03 Brook	ford Cir	cle #T.	. Piko	gwil	
o Tanto	20a. Method of Disposition	20b. Place of D	isposition (Neme of			20c. Location -		
0 85 8	1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal	from State cometery.	cremetory or other pl					
L. Pages 1. Transit of He tant if Herr or oth	4 Donalis 5 □Other (Specify)	Garri	son Fore	st Vet.	8/24/0	0 Owin	gs M	ills, Md
a management	21. Signature of Funeral Service Licenses		22. Name end Add	ess of Fecility				
W 88EE8	A trime. It	and the second s	4300 Wab		Baltin	more M	d 2	1215
	23a. Part1. Effer the disease, or complications	TOTAL DESIGNATION OF THE PARTY						Approximete
Dhusisian	annock or heart failure. List only one cause	e on each line.						Onset and Deeth
/Physician /Medical	Immediate Cause (Final	co. d = 000	1.40000	mu	to.			
Examiner	disease or condition resulting in death)	Seudomi Due to (or es e co	TXONNO	Lev	LYONG	1		
		Due to (or es e co	risequence of):					
D, axecuted in and instransit Examiner	a	enyala	TON					
60, be axecuted ician and burial-transit	Sequentially list conditions,	Du to (or es a co	nsequence of):					
Sign Sign Sign Sign Sign Sign Sign Sign	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thei milieted events c	-						
	thet initiated events resulting in death) Last	Due to (or es e cor	nsequence of):					
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Box eath cert attending for use	d						1	
death death a stier ad for u	Part II. Other significant conditions contributing	to death but not resulting in t	he underlying cause o	iven in Part I	23h Did to	shacco usa co	ntribute to	the cause of death?
P.O. B. that the death defached for Physicia	Tarti. Other significant conditions contributing	to death but not resulting in t	no underlying cause g	rectificates.		/	3 □ Prob	
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I Para he sa he page					1 🗆 Y	es No	1	Yes 2□ No
Vital Re- icien: The lav certificate has irector, page 2	25. Was case referred to medical			26 Place of Dee	th (Check only or	ne)		
of Vital Representations of Vital Representations of the page 2 rail director, page 2 rail of the Comp	examiner?	1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA	ther: 4 Nursing H	. /	ence 6 Oth	or (Specifi	4)
Phys Phys raidis					28d. Describe h			,
After fune		Dete of Injury (Month, Dey Year) 28b. Tin	Jry W	ork? ⊒Yes 2⊟No				
Division or Attending Programmer after the Unector: After the India in by the funers Certification:	a Doublide GD Could not be	OH			28f. Location (Si	trant and Alumb	ar ar Pura	I Poute Number
or An in by in by	4 Homicide determined 28e.	Plete of Injury - At home, fam building, etc. (Specify)	n, street, rectory, office		City or Town	n, Stete)	er or nurar	Houte Number,
O SESTED O		NH						
Hospital 24 hours Funeral stay filled	29a. Certifier Certifying Physicien: 1 Certifying Phys	o the best of my knowledge, of the basis of examination and/	deeth occurred at the	time, date and place	, end due to the c	ause(s) and ma	anner es sta	ated.
		menner stated.	or alreadigation, in my	opinon, deem occu	noo at the third, O	and one piace,	5.10 QUE (D	110 00000(0)
To the comple	29b. Signeture end title of certifier	11.5	29c. Licer	nse number	2	9d. Date signe	d (Month, E	Day, Year)
	WILL STREET	1 MD	DO	7533	76	86	HE	(27)
	20 Name and officers of	Lanuar of death from 00 1 77	Drint)		. ^	ı	L	
	30. Name and address of parson who completed	cause of deeth (tiem 23a) (T	(Print) fa	15th L	(D)	200	116	
_	31 Data filed (Martin Sauth	10UV	1 tu	4.		OLU	UT	
State	31. Dete filed (Month, Dey, Year) AUG 2 3 2000	32. Addistrer's Signature	4. In	12 .				



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State of Maryland / Department of Health and Mental Hygiene 00 266 | 8

				Certi	IICall	e of L	Jeam			Reg. No.		
	1. Decedent's Nama (First, Middle, L	ast)						2	Date of Dea	ath Day	Year	3. Time of Death
Physician /Medical	Edward J. Gorals	ki Sr.							Augus			12:38 P.N
Examiner	4a Facility Name (If not institution, g	ive street and number)		1102		4	b. City, Tov	m, or Loca	tion of Death	4c. County	of Death	
	Maryland General	-						imore		N/		
Funeral Director	5. Social Security Number 6. 218–16–2271	Sax 7. Aga	(In yrs. last I	munuay/	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birt (Month, Da)	1925	9. Birthp Court Mary	laca (State or Foreigr try) land
2 .	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	um or Local	tion						1	0d. Inside City Limits
28a-1 sho notfiled at rector	Maryland N/A			imore	(IOII							12 Yes 2 No
Ta or 28s-1 at be notified	10e. Street and Number 248 S. Wolfe St.				101. Zip					10g. Citizen of 1 USA	What Cour	try?
at, or thems 2 Examiner mu by Funerr	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 127 ves 2 □ No If Yes, Give Yaar or Datas: W			s Deced aa, spec		spanic Orig n, Mexican, Specify:	in? (Specif Puerto Rid	y Yes or No- can, etc.)		ca - Amaric ck, White,	etc.
State State	15. Decedent's I	Education	16	a. Deceder	nt's Usua	i Occupa	ation during most	of working	1.00	16b. Kind of B	usin ess/i nc	dustry
or the Medical.	Elementary/Secondary (0-12)	College (1-4or 5+)	Sheet	NOT us	a ratired)	or working		Factor	Y	
d other	17. Father's Name (First, Middle, Las	1)					18. Mother	's Neme (/	First, Middle,	Meiden Sumar	ne)	
Menta Menta affic en To B	John Goralski						Karo	line	Polek			
Pull I	19a. fnforment's Name/Relationship		15	9b. Meiling	Address	(Street	and Numbe	r or Rural F	Route Number	er, City or Town	State, Zip	Code)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Philip Goralski/S	Son		248 S.	. Wo	lfe	St. B	altim	ore, M	Maryland	212	31
nert of He nt: if Berr ny or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		came	of Disposit tery, crema imore	tory or o	ther plac			Date 24/00	20c. Location Baltimo		
Departments any Injury	21. Signature of Funeral Service Lice	ensee 1) a hos	CFSI	D Day	vid .	J. W	eber	Funer	al Hom	nes, P.A		
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the	he death D							ore, Mar	yland	Approximete
physician and is the burial-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	D b	Due to (or as	a conseque	ence of):						1	
2 2	resulting in death) Last	l d	00 (0) aa i	conseque	rice or,							
the att	Part ff. Other significant conditions	contributing to death but	not resulting	in the und	erlying c	ausa giv	en in Pert I.	1.5	23b. Dfd 1	obacco une co	ntribute to	the cause of death
7 6 F									10	Yes 2 No	3 Pro	bably 4 Unknow
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7 303 If Under 1 Ye

Months

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death

4b. City, Town, or Location of Death

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last)

ERNEST 4a Facility Neme (# not institution, give street and number,

Year or Detes:

College (1-4or 5+)

12M 20F

BLOOM

10:00 AN 2000 4c. County of Death

Birthplece (State or Foreign Country)

SC

10d. Inside City Limits

1₽ Tes 2□ No

Funeral

Director

or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after "natural",

nd Mental Hygiena. marked other than permit. Pages 1 and 2 should be file Department of Health and Mental by Important: if item 27 is marked oth-eny injury or other traumatic event page.

Maryland 21215-0020

Physician /Medical **Examiner**

D.0

of Vital Records.

Division

Director: A completely filled in by To the Hospital within 24 hours a To the Funeret D

Be Completed by Physician/Medical Examine Medical Certification: To

101-16-4759 Usual Residence of Decedent 10a. Stete 10b. County Funeral Director 10e. Street and Number 11. Meritel Stetus 1 Never Merried 2 Merried Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 17. Fether's Name (First, Middle, Last) WILLIAM 19e. Informent's Neme/Reletionship (Type, Print) WILKINSON NORA 20e. Melhod of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee

12. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2 No

10c. City, Town or Location

STREET

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify

BLACK 16b. Kind of Business/Industry 18. Mother's Neme (First, Middle, Meiden Sumame)

Rece - American Indian, Bleck, White, etc.

10g. Citizen of What Country?

UNKNOWA 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, cremetory or other place)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

8-24-00

-UNDEN!

MOUNT ZION CEM 22. Name end Address of Fecility HOWELL 4600 LI BETHY HUISAY AVE

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Ceuse (Finel disease or condition resulting in death)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events

Due to (or es a consequence of)

Due to (or es e consequence of)

Due to (or es e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No

24e. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

1 Yas 2 No

25. Wes case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 N Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other:

27. Magner of Death 1 Naturel 2 Accident 5 Pending investigation 3 Suicide

4 Homicide

6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28b. Time of 1 Yes

4 Nursing Home 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 281. Location (Street and Number or Rurel Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier

29b. Signeture and title

2 No

29d. Dete signed (Month, Dey, Year)

31. Dete filed (Month,

oaks

Registrar DHMH 16 Rev 6/95

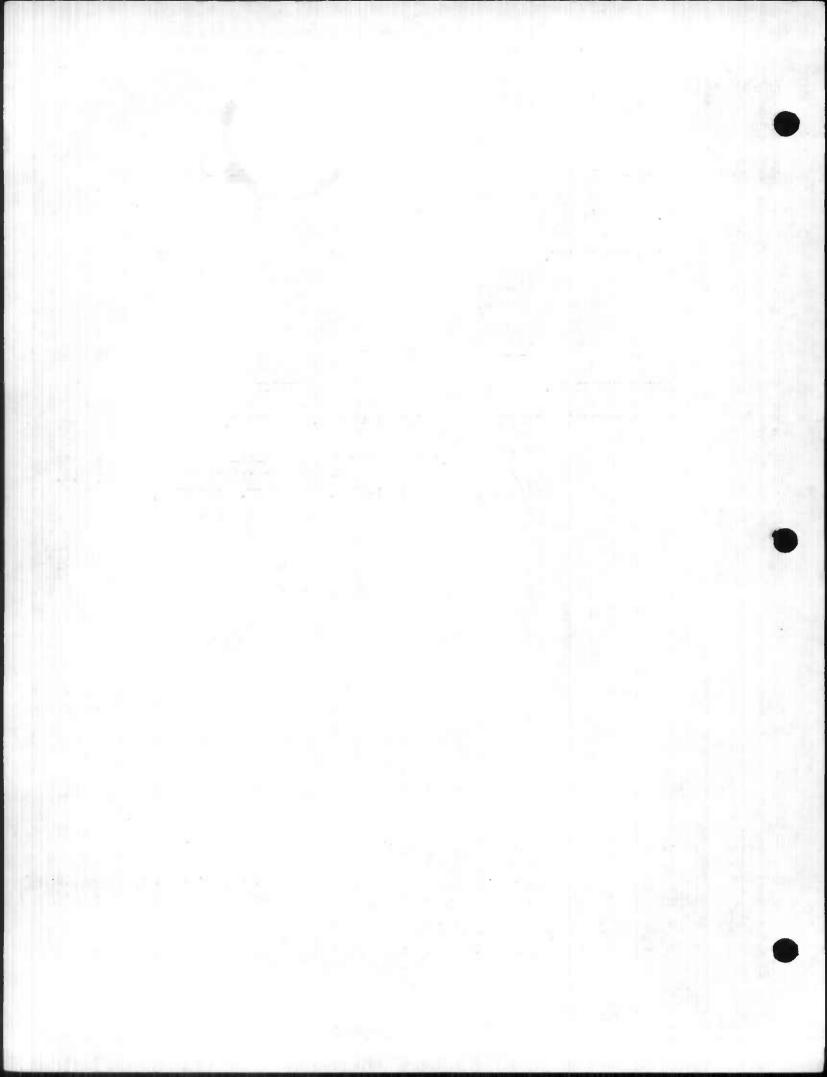
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Tima of Death Day **Physician** Year lau ugust 2000 /Medical 4a Facility Name (If not Institution, give atreat and nyimber) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAR IMORE If Under 5. Social Security Number Age (In yes, last birthday) Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 110M 20F Director 219-52-6427 NC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. N/A BALTIMORE 1 ☑ Yes 2 ☐ No Director 10a. Street and Number 10f. Zip Code 10c. Citizen of What Country? Nerns 23s or 301 McMECHEN AVE. 21217 USA death Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give "natural", or altimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mentel Hygiens important: if frem 27 ie marked other tra eny filury or other traumatic event, train phose. -8--0-LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be CLAUDE GUNTER SR. WILLIE MAE ALFORD 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) TRELIA GUNTER (DAUGHTER) 205 10th AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1) Burial 2 Cremation 3 Removal from State MT.ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 8-21-2000 BALTIMORE, MARYLAND 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Puneral Service L 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a Part. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons certificata be execu Box 68760 mmun Physician/Medical the th Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the suse of death? signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by Records. Be Completed 24b. Wera autopsy findings available prior to 24a. Was an autopsy completion of cause of deeth? cate hes b 2 NO certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien:
44 hours after deeth,
Funerel Director: After this certifical
eth filled in by the funeral director; 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury Of Injury Of Market Street, factory, office State of Street Manner of Death 28d. Describe how injury occurred Mater Vehicle 28c. Injury at Work? 1 Naturat 5 Pending calision investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide CHOI Batt. Not Pike Catonsville, IMD Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier To the Within 2 To the 25b. Signature and Atle of ceptities 29c. License number 29d. Date signed (Month, Day, Year) 16 oru d address of person who completed cause of death (Item 23a) (Type, Print) Stone 4mme 31. Date filed (Month, Day, Year) AUG 2 3 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

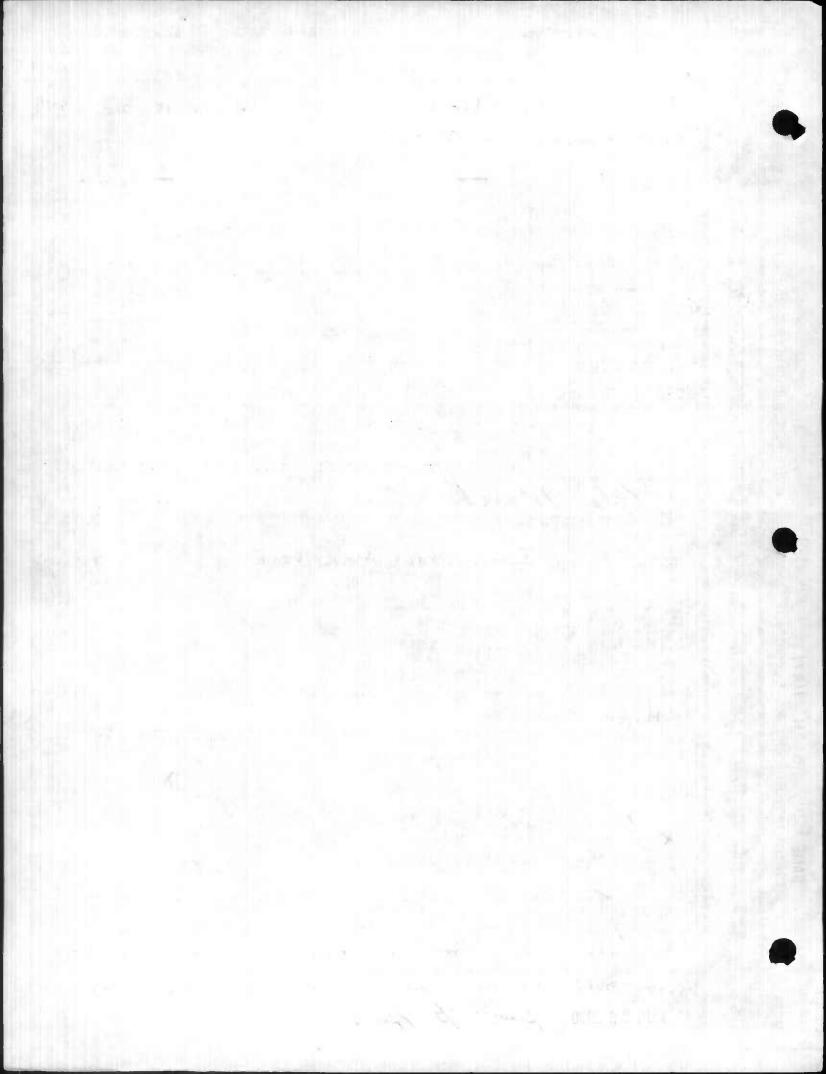


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State of Maryland / Department of Health and Mental Hygiene 2662

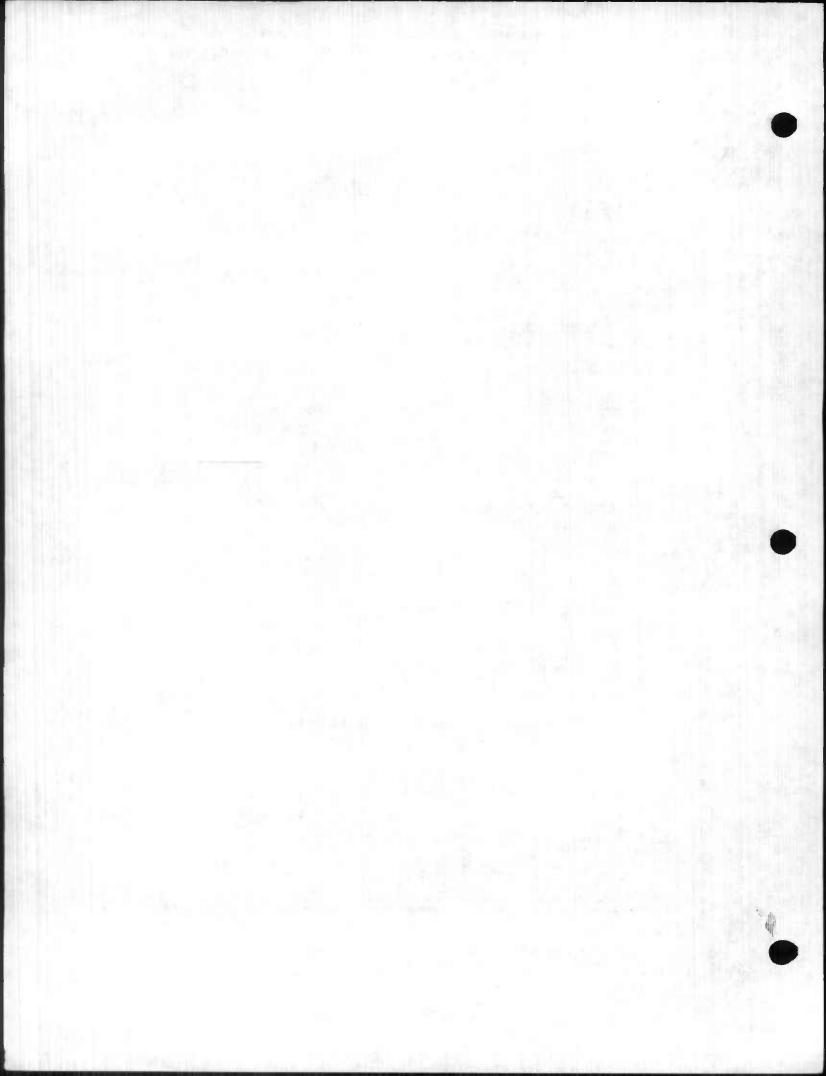
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State of Maryland / Department of Health and Mental Hygiene 26623 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death John E. Hittel Month Day Year Physician 0810 August 21 2000 /Medical 4a Facility Neme (If not institution, give street end number)
St. Agnes Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Day, Year, FEB. 20, 1926 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys 1♥ M 2□ F Months Hours 213-20-8178 74 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at MD N/A Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 549 Lucia Avenue 21229 IISA Funeral 12. Wes Decedent Ever in U,S.
Atmed Forces?
1 ⓑ Yes 2 □ No
I Yes, Give
Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indien, Black White etc. 1 Never Merried 2 Merried altimore. Maryland 21215-0020 1 Yes 2 No Specify: white Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Supervisor Solo Cup Co. permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry F. Hittel Anna M. Fuhmanick 19s. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Hittel - wife 549 Lucia Avenue, Baltimore, Md. 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 8/25/00 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete Baltimore, Md. Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Neme end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075 1101142 and the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, but or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Zday Sul dural Noem tom /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner been signed by the attending physician and should be detached for use as the burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Cerebrassely Auchts þ 24b. Were autopsy findings available prior to completion of cause of death? Dishete Mull. As Completed 24a, Wes an autopsy It you this 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Ampatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Dey Year) 27. Menner of Death Certification: 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident or Attend after death Director: / 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 1734551 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) , karule 405 Rech & Rel de to Commille wo > 1200

DHMH 16 Rev 6/95

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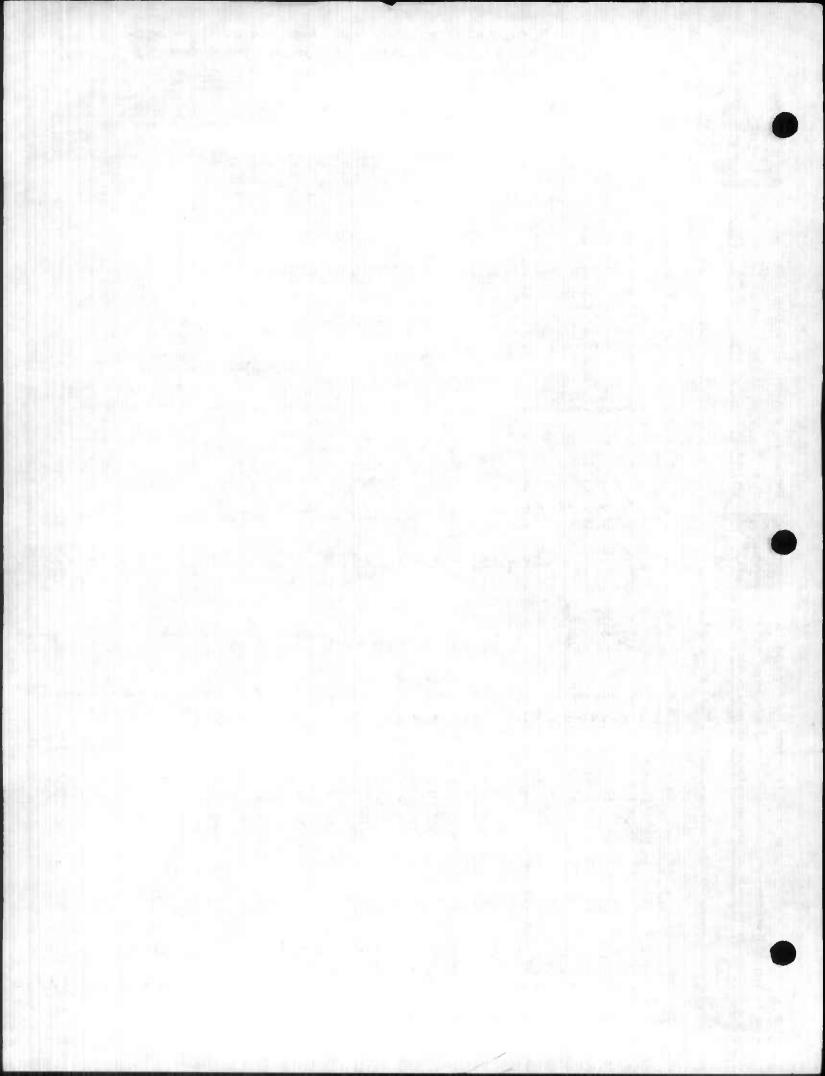
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Registrar



Amended # 25, P.G. GC, 7/6/00 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Day Month Year JUNE L. **Physician** HINES MAL 12,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Houra Min. 8. Dale of Birth (Month, Day, Year)
April 3, 1939

8. Birthplace (State or Foreign Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 200F 214-36-2882 61 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits Maryland Calvert North Beach Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Examiner must be P.O. Box 758 20714 U.S.A. Nerna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed A Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mertal Important: If Item 27 is marked on any Injury or other traumented on pages. Be Charles V. Jameson Helen M. Collins 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lynnett Hines-Hutchinson 3202 Meadow Lane Chesapeak Beach, MD 20732 20a, Method of Disposition

AB Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ft. Lincoln Cemetery May 17,2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service License 3401 Bladensburg Rd. Brentwood, MD 20722 Moa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart alure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Heratic Failure Examiner Due to (or as a consequence of): Physician/Medical Examiner Acetaminophen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attending physician and for use as the bunal-tran Due to (or as a consequenca of) Box 68760, Due to (or as a consequence of) ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed?

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

26625

3. Time of Death

1 Yes 2 No

Approximate erval Between Onset and Death

1 Yes 2 No

4:45

The law requires that the death certificate be axecuted Division of Vital Records, P.O. at or Attending Physician: T s after death. It Director: After this certificated in by the funeral director, p To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

Be

Certification: To

Medical

11. Kli Benge

investigation 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 □ Yes 2 ØNo streef, factory, office 28	UNKNOUN II. Location (Street and Number or Rural Route Number, Cry or Town, State)
			d due to the cause(s) and manner as stated. I at the time, date and place, and due to the cause(s)
title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
re Roskim	an, mo	AT 243 8941	6 May 12, 2000
esa of person who cor	npleted cause of death (Item 23a) (Typ	e, Print)	
E ROTHMA	N UNION MEMORIA	AL HOSPITAL BALTIMO	IRE MARYLAND 21219

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yes 2 No

1 Yes 2 No

28d. Describe how injury occurred

Registrar

JUL 0 6 2000

LAURIE ROTHMAN

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

Kukimas 30. Name and address of person who completed cause of death (Item 23a) (Type, F

examiner?

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

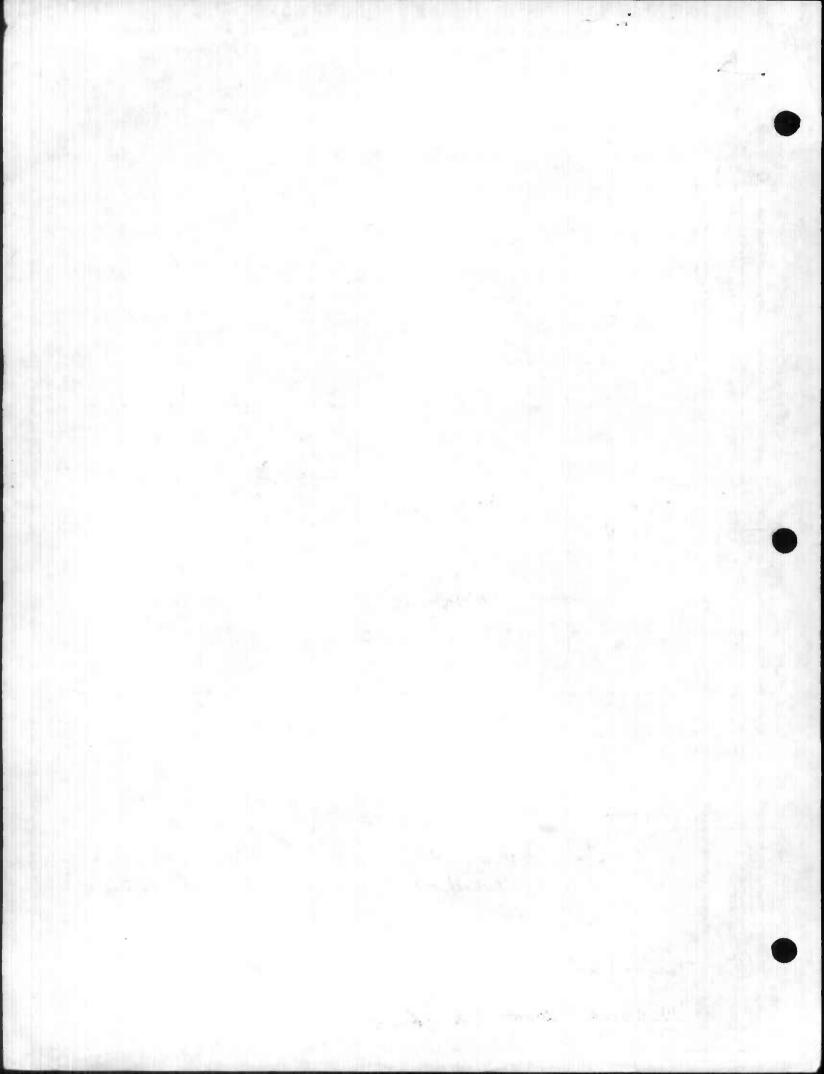
32. Registrar's Signature

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

UNION MEMORIA

28b. Time of

Injury

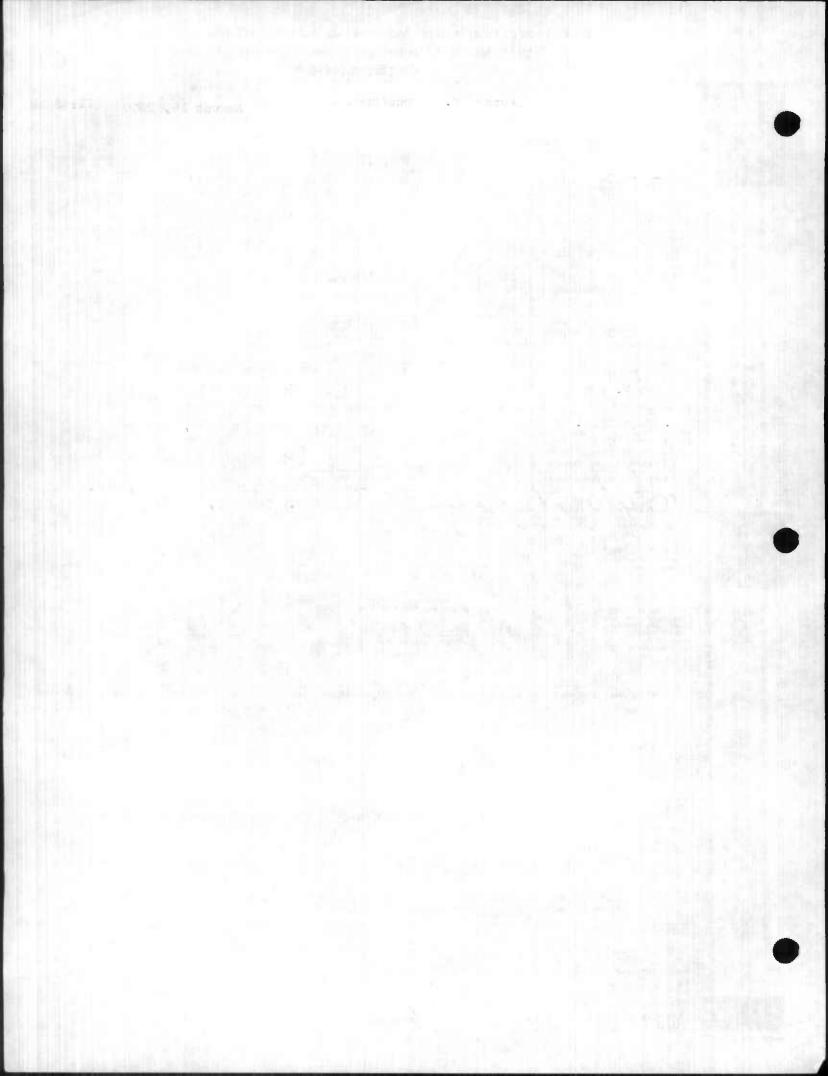


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State of Maryland / Department of Health and Mental Hygiene 00 26626

				Certificate of Death Reg. No.											
-		ical Ab City Tou									2. Date of Death Month Day Yeer			3. Time of Death	
	Physician (Madieal							echt				August 19, 2000		11:48 AM	
	/Medical Examiner							wn, or Lo	ocation of Dea		nty of Deeth				
	Examine	8146 Gray Haven Road Dunda								ında	1k	k Baltimore			
-	Cunaval	5. Social Security Nur			7. Age (In yrs.	last birthdey)		er 1 Year	If Under	24 Hrs.		e of Birth onth, Day, Year) 9. Birthplace (State or For Country)			
	Funeral Director 218-26-6833 1□ M 2♀ F 70						Months Days			Hours Min. (Month, D				land	
		Usual Residence of D			70						ounc 2	.5/1550	True y	20110	
	Mand Mand	10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limit										IOd. Inside City Limits			
	Men to	Maryland Baltimore Dundalk 1 Tyes 2											1□Yes 21 No		
	with the Maryland to or 28a-f show to notified at Director	10e. Street and Numb	er			10f. Z	10f. Zip Coda			10g. Citizen of Wh		of What Cour	ntry?		
	with with	8146 Gray Haven Road 21222										United States			
fier death with the Maryland r herns 23s or 28s-f show sine must be notified at Funeral Director			-		edent Ever in L	19 13	Was Dec	adent of h	dispenie Ori	ain? (Sn	acifu Vas or N				
		11. Marital Stetus	d OFF Marriad	Armed Forces?		7,0.	13. Was Decedent of Hispenic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F			Rican, etc.)		14. Race - American Indian, Black, White, etc.			
20	by F	1 Never Married		a 1 ☐ Yes 2€ No Specify:						hite					
21215-0020													director.		
7	be filed within 72 ho tal Hygiene. I other than "natur event, in Middell Be Completed		 Decedant's E y only highest gr 		1) 16a. Decedent's Usuel Occ (Give kind of work don			ork done	ne during most of working			16b. Kind of Businass/Industry			
12	ne.	Elamantary/Second	dary (0-12)	College (1-4or 5+)			fe. DO NOT use ratired)				37.2				
	Il Hygie other t	9 Years				omem	emaker			(E) . A A' 1 14	07	e			
n	d out	17. Father's Name (F)					18. Mother's Name (First, Middla			i, Maiden Surname)			
yla	should be nd Mental marked or imatic ev	Justus P.							E	lisak	eth Ho	ldorf			
Maryland	d 2 should be filed the and Mental Hyg 7 is marked othe traumatic event,	19a. Informant's Nan	ne/Relationship	Type, Print) (F	usband) 19b. Meili	ng Addre	ss (Street	and Numb	er or Run	al Route Numi	per, City or To	wn, Stete, Zip	Code)	
	CHNF	Mr. Kenne	th M. H	ousekne	cht	8140	6 Gra	чу На	ven R	load	Dunda	lk, Mar	cyland	21222	
ore.	of Her Man	20a. Method of Dispo				Place of Dispo	sition (No	other pie	ce)	1	Date	20c. Locatio	on - City or To	own, State	
E	Peges net: If It iry or o	1 Burial 2 □			State	0 %			8/2	2/20	000	Baltin	Baltimore, Maryland		
Baltimore,	교원관등 .	4 Donation 5 Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility													
B	Depa Impo any I	Duda-Ruck Funeral Home of Dundalk, Inc.													
		7922 Wise Ave. Dundalk, Maryland 21222													
411		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Shock, or heart failure. List only one cause on each line. Approximete Interval Batween											Intarval Batween Onset and Deeth		
	Physician				-									Criset and Deeth	
	/Medical Examiner	Immediate Causa (Fi	inai	· MY	OCA	RDIA	L	11	JFP	TRC	TIOIT	V'		1047	
		disease or condition resulting in death) A MYOCARDIAL INFARCTION' Due to (or as e consequence of):													
	P is S		CORONARY ARTERY DISEASE									IYEAR			
	ficate be assecuted physicien and its the burial-transit edical Examiner	Sequentially list cond	ditions,		Due to (or as a consec	quenca of):							
30,	ve ax	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that shifted events Due to (or as a consequence of): 10 YEAR Due to (or as a consequence of):										10 YEARS			
68760,	erificate be asecu sing physicien and se as the burial-tra Medical Exar	that initiated events resulting in death) Last Due to (or as a consequence of):													
9															
Box	attanding for use a			d											
	death o	Part II. Other signific	ant conditions	contributing to de	eath but not res	sulting In the u	nderlying	cause gh	ven in Part).	23b. Dlo	tobacco use	contribute t	o the cause of death?	
P.0	ed by th detache							1	Yss 200 N	lo 3 Pro	bably 4 Unknown				
	es that the death certigned by the attendin be deteched for use by Physician/N	MYASTHENIA GRAVIS.													
Division of Vital Records,	requires een sign hould be										24a. Was an autopsy 24b. Were autopsy find				
0	been s should									peri	ormed?	00	vailable prior to empletion of cause death?		
3e	The law requir sate has been si page 2 should Completed										-				
=	certificate he rector, page									Yas 200N	0 11	Yes 20 No			
1	Physician: this certific ral director,	25. Was case raferre examiner?	d to medical	44				-		e of Deat	h (Check only	one)			
=	Z Sip	1 ☐ Yes 2 N	lo		Inpatient 2	ER/Outpatie	nt 3 🗆 E	UA		ursing Ho	ma 5 DRes	idence 6 🗆	Other (Special	fy)	
L	her the	27. Manner of Death	5 Panding	28a. Date (Mont	of Injury th, Dey Year)	28b. Time o Injury	1	28c. Inju Wo	ry et rk?		28d. Describe	how injury oc	curred		
Ö	ath.	2 Accidant	invastigatio		M 1 Yas 2 No										
<u>×</u>	er de by t	3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	Se di Di	27. Manner of Death 1 Natural 2 Accidant 3 Suicide 4 Homicide 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury et Work? 1 Yas 2 No 28d. Describe how injury occurred 28d. Describe how in													
	To the Heaptal or Atlanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.													
	plete	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to the cause(s) end manner stated.													
	within to the comp	29b. Signature and title of certifier 29c. License number 29d. Deta signed (Month, Dey, Year)										Dey, Year)			
	,	10	ep	- 5	M.	M.D.	I	33	40	7	441	8/21/00			
	0	30. Name and addres	s of person who												
	10	DEEPAL		TH,	2-01	IALLS F	= P	TVP	NUE	B	ALTI	MOR	E M	0 21222	
	Chaha	31. Date filed (Month,			egistrar's Sign					/					
,	State Registrar	AUG 2 3		howw	1 4	don	aka								
	ricgistrui	HUULOU	LUUU	Part	1	1200	-								

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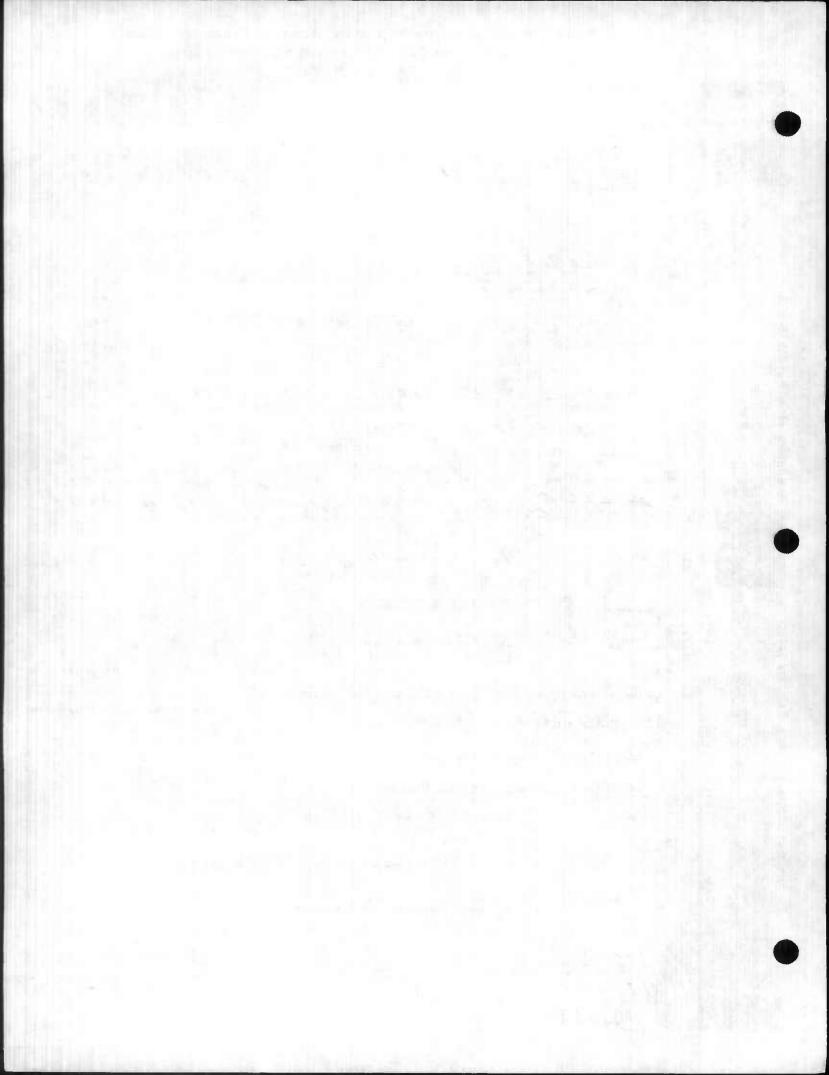


State of Maryland / Department of Health and Mental Hygiene

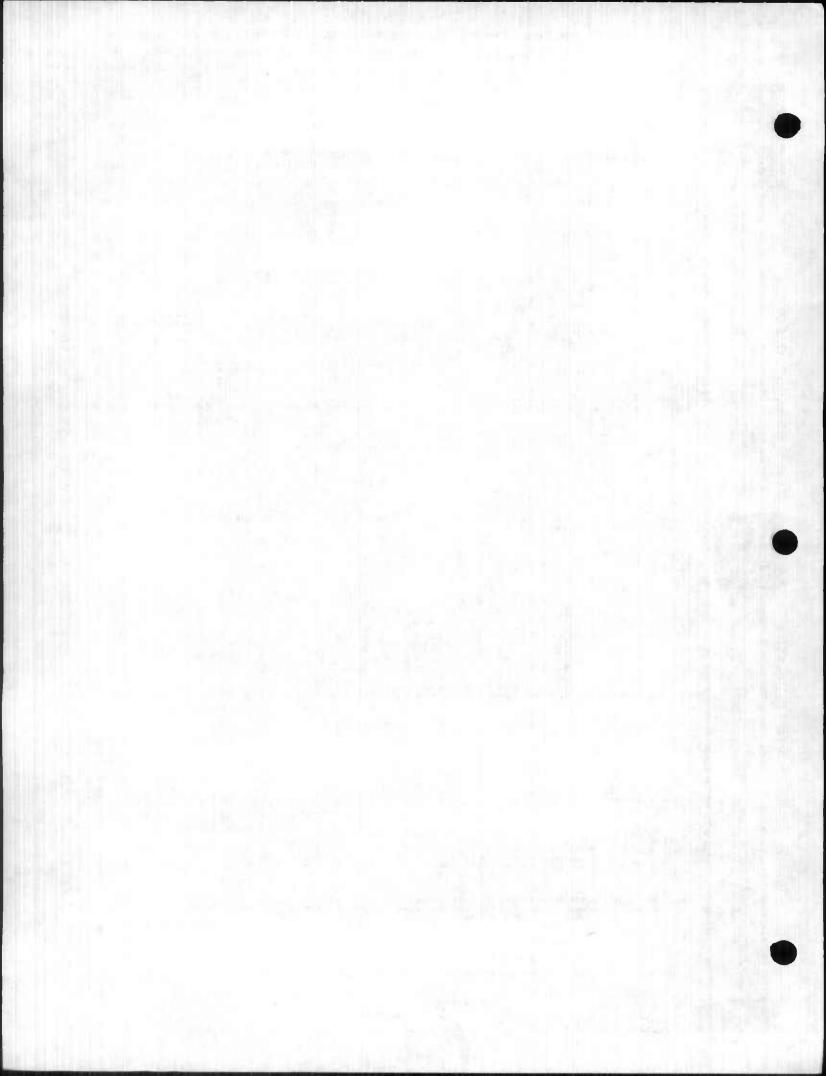
Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Year **Physician** 0156AM /Medical 4b, City 4c. County of Death ne (If not institution, give street and number) Examiner NA MORE B. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Days Min 125M 20 F 213-01-3385 81 **Director** Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Md BALTIMERE. Director 10e, Streef and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 1224 7230 USM Funeral 12. Was Decedent Ever In U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 KNo Specify: WHITE b 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WHITE ROSE CO. NA 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father'a Name (First, Middle, Last) rid Mental marked of affoods be BUNARD 102 and a 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 of the Health : 21224 Md LINEA IGA ZRAGUIX 7230 CONLEY 8 Pate 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1, Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) MURCAWN 21. Signature of Funeral Service Licensee 22. Name end Address of Facility UNERH HARTLEY Md 21234 7527 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediete Cause (Finel disease or condition resulting in death) /Medical 82120 **Examiner** Due to (or as a consequenca of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) The law requires that the death certificate be execu Box 68760. Due to (or as a consequenca of): P.O. Part II. Other significant conditions cogtributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Medical Certification: To Be Completed by i or Attending Physician: The law requires the after death.

Director, After this certificate has been signed in by the funeral director, page 2 should be a 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? 2/2/No 1 Yea 2 No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 27. Menner of Death 28b. Time of 28d. Describe how injury occurred tnjury at Work? Division Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, atreet, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of deeth (Item, 27a) (Type, Print MD. 31. Date filed (Month, Day, Year) AUG 2 3 32. Registrer's Signature State 2000 oaks Registrar



Rollin	s Johnson, Jr.			Certificate	of Health and of Death		Reg. No.	2662	
Physician	Decedent's Name (First, Middle					2. Date of De Month	ath Day	3. Time of	Death
/Medical	Henry Rollins					Augus			9 A.M
Examiner	4a Facility Name (If not institution University of I			ter	Baltimo:	Location of Death	4c. County	of Death N/A	
Funeral Director	5. Social Security Number 212-42-5592	6. Sex 1☐M 2☐ F	Age (In yrs. last birth		eer If Under 24 Hr: ays Hours Min		th ly, Year) , 1945	9. Birthplace (State of Country) MD	or Foreign
,	Usual Rasidence of Decedant		10s Chu Tour	as Lacation				Land Invide O	1a . 6 too 16 o
Le nomina at Director	MD Balt:	more	10c. City, Town	or Location				10d. Inside C	2 □ No
or 28e-f s	10e. Street and Number	rmore	Essex	10f. Zip Co	de		10g. Citizen of \	What Country?	
rms 23s or rmst be neral Dir	1631 Richenback	ker Rd. Ant	· C	2122			United		
r items 234 other must	11. Marital Status	12. Was Decede	nt Ever in U,S.	13. Was Decedent	of Hispanic Origin? (Specify Yes or No		e - American Indian,	
2	3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Giva Year or Date	₫No	1 ☐ Yes 2 ☐	Cuban, Mexican, Pué No <i>Specify:</i>	rto Rican, etc.)	Specify Bla	ck, White, etc.	
e le	15. Decedant	's Education	16a. C	ecedent's Usual O	ocupation one during most of we stired)	orkina		usiness/Industry	
nt, the Medical	(Specify only highes Elementary/Secondary (0-12)	College (1-4	Of 5+)	ile. DO NOT use n uck Drive		nning	Trucki	ng Company	
vent, the	17. Father's Name (First, Middle,	(aet)	11	uck blive		me (First, Middle,	Maiden Sumen	10)	
	Warmana D-11!		r.			B. Stewa:		10)	
To	19a. Informant's Name/Ralations	nip (Type, Print)	19b. I	Mailing Address (St	reet and Number or F	Rural Route Numb	er, City or Town,	Stete, Zip Code)	
V	Ms. Martha Dot	son-Sister	88	69 Flower	stock Rd.	, Columb	ia, MD 2	21045	
Important: If Itam 2 any Injury or other pnce.	20a. Method of Disposition	. 22	cometen	Disposition (Neme of cremetory or other	of place)	Date Aug 25	20c. Location -	City or Town, State	
mportant: If it is any injury or once.	1 Burial 2 Cremation 4 Donation 5 Other (S)			uke's Cem	etery	2000	Reiste	rtown, MD	
any injury	21. Signature of Funeral Service	Licensee	int	Smith	ddress of Facility & Williams ast Baltim			P.A. timore, MD	
the burial-transit dical Examiner	Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate	a. Multi	Dua to (or as a co	nsaquence of):					
etached for use as the buria Physician/Medical E	Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a co	nsequenca of):				1	
the at hed fo	Part II. Other significant condition	ns contributing to death	but not resulting in t	he underlying caus	e given in Part I.	23b. Did	tobacco use co	ntribute to the cause	of death?
0						10	Yes 210 No	3 Probably 4	Unknown
shoul						24a. Was	an autopsy ormed?	24b. Were autopsy available prior completion of confederation	0
page 2						12	Yes 2□No	1 Yes 2	No
rector, pag	25. Was case raferred to medical				26. Place of Di	eath (Check only o			
To Be	axaminer? 1) Yes 2 No	Hospital:	atient 2 ER/Outp	atient 3 DOA	Other:	Home 5 ☐ Resi		ner (Specify)	
= 10	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		Day Year) 28b. Tir -2000 1:4		Injury at Work? 1 ☐ Yas 2X No		how injury occur t was st		118
by the	3 Suicide 6 Could r	ned 28e. Place of building	Injury - At home, fam etc. (Specify)	n, street, factory, of	fice	281. Location (City or To	Street and Num! wn, Steta) O()	ber or Rurel Route Num Virginia	Avenu
De Ce			H	ouse			Marylar		117 0110
completely filled in by the funer Medical Certification:		g Physician: To tha be Examiner: On the basis and manner	of examination and/						s)
No N	29b. Signaturitiend title of certifier	stane	~,M	D 29c. Li	O.C.M.E.			22, 2000	
7)	30. Name and addless of person	who completed cause of	f death (Item 23a) (T						
	Joseph Pestani 31. Date filed (Month, Dey, Year)	-	strar's Signature	111 Penn	Street, B	altimore	, Maryla	and 21201	
State	3, 100, 100,	J. Hegi	The state of the s	Anna Va					

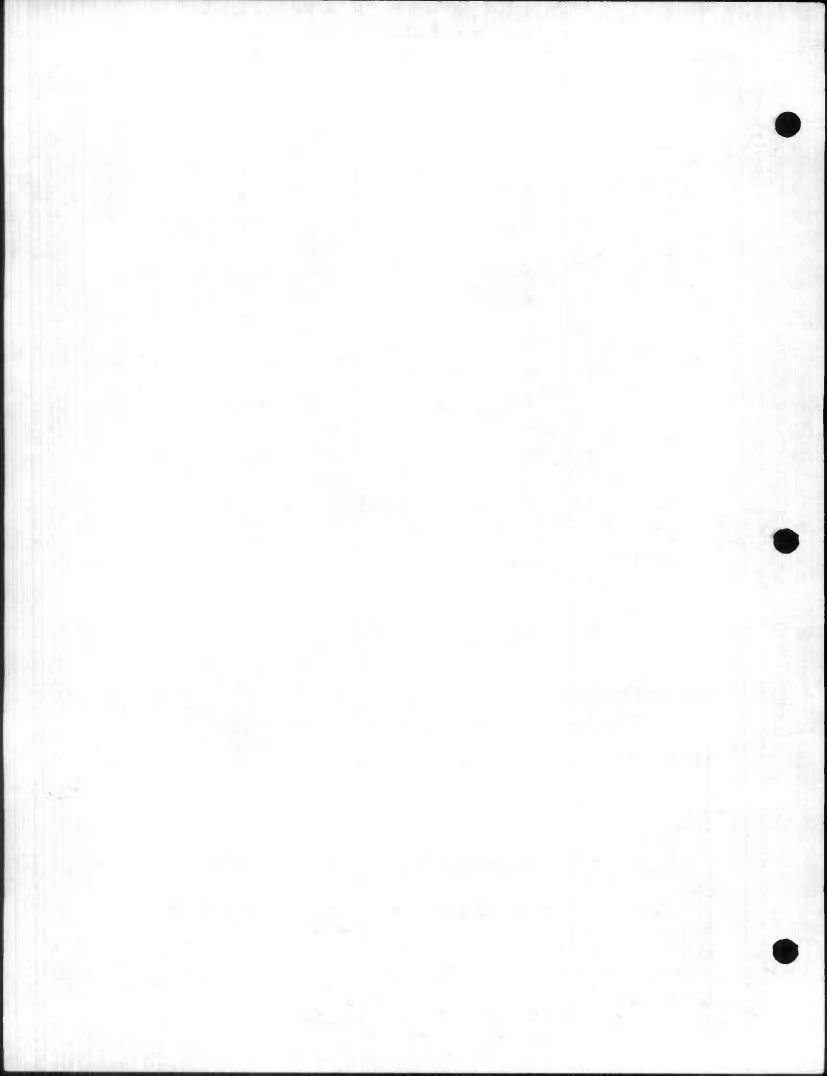


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene LEWIS KEALON 27, PER MEO Certificate of Death AMEND ITEMS: #23 PART I, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, 2000 Year Physician Month AUG. 9:45 AM Lewis Kealon /Medical 4b. City, Town, or Location of Death 4a Facility Nama (ff not institution, giva street and number) 4c. County of Death Examiner /A BALTIMORE 1417 NORTH FULTON AVENUE 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 01-17-48 Birthpiace (State or Foreign Country)
 NC 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F 241-80-9748 Director Usuel Residence of Decedent with the Maryland 10e. Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner mant be motified at MD 1 N Yes 2 No N/A Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123a or 2 1417 FULTON AVENUE Funeral 21217 filed within 72 hours after death 14. Race - American Indian. Heme 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: Maryland 21215-0020 ò BLACK þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname) JANITOR 17. Father's Name (First, Middle, Last) and Mental I Pages 1 and 2 should be LIST WILLIS MAUREEN KEALON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MARY KEALON/WIFE M Haalth 1917 W. NORTH AVENUE, BALTO., MD. 21217 other Saltimore, 20b. Place of Disposition (Name of cametery, crematory or other place)
KING MEM PARK Date 20c. Location - City or Town, Stata 20a. Method of Disposition Department of Himportant: If ite ò 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/23/2000 BALTO., MD eny injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 23a. Part I finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND Immediate Cause (Final disease or condition resulting in deeth) /Medical DIABETES MELLITUS Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequanca of): pue Box 68760. aftending physician Physician/Medical Due to (or as a consequence of): use as the P.O. 23h. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 2 Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? page 2 should Be Completed 24a. Was an autopsy this certificate has LO Tes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physicien: 25. Was casa referred to medical 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) AT SCENE 1 Yes 2 No Medical Certification: To s after death.
If Director: After this ad in by the funeral d 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Canding investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16, 2000 AUG. O.C.M.E Ullinte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lowell 111 Penn Street, Baltimore, Maryland 21201 HARGARIAN Date filed (Month, Day, Year) 32. Registral's Signature State AUG 2 3 2000

Registrar **DHMH 16 Rev 6/95**

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26630 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Death AUGUST KRYSTEL 2 I Day **Physician** 2000 KORTTZER 7:50 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Dan 4a Facility Nama (If not Institution, give street and number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE ar If Under 24 Hrs CITY If Linder 1 Van 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Baltos md Yrs Director idehos of Decede 10d. Inside City_Limits 10a. State 10b. County 10c. City. Town or Location 1 Tes 2 No M move Funeral Director must be not 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Herrie 23s or 4.5: Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Examiner 1 Never Merried 2 Merried Specify: P 1 Yes 2 □ Specify: 1ack Maryland 21215-0020 6 If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) other than (1-4or 5+) Unemb loved 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Be Koritzer 9/2512 Pages 1 and 2 should be nent of Health and Mental prown is marked 7 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parents Back, nd. Wayne + Alesia st. 805 Lynhust Health. Nem 27 i 21229 LOVITZER Baltimore, 20b. Place of Disposition (Name of cemetery, cramatory or other place) important: If he any lojury or oth 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ABurial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 8/25 Bactimore Nat'L Cemetery atons uille 21. Signature of Funeral Sarvice Licensee /LEWIST. Gwynn 22. Name end Address of Facility LEWIS ewas 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Live 1215-6393 Approximata Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Pulmonary Hypertension 7 DAYS Examiner Due to (or as a consequance of) Physician/Medicai Examiner 7 DAYS Hypoplasia Amonary been signed by the attending physician and should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): The law requires that the deeth certificate be execu Division of Vital Records. P.O. Box 68760. Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Left lung agenesis 1 Yea 2 No Be Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Total Anomalous Pulmonary Venous Return completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No this certificate Physician: 25. Was case raferred to medical 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA edicai Certification: To 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending After 1 Natural 2 Accident 5 Panding Investigation s after deem. 1 Yes 2 No 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and dua to tha causa(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29a. Certifier

DHMH 16 Rev 6/95

State Registrar

MICHELLE SMITH, MD 31. Data filed (Month, Day, Year)

AUG 23

29b. Signature and title of o

JOHNS HOPKINS HOSFITAL GOD NORTH WOLE STEET, BALTIMORE, MALKUND 2128 7 32. Registrar's Signature

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

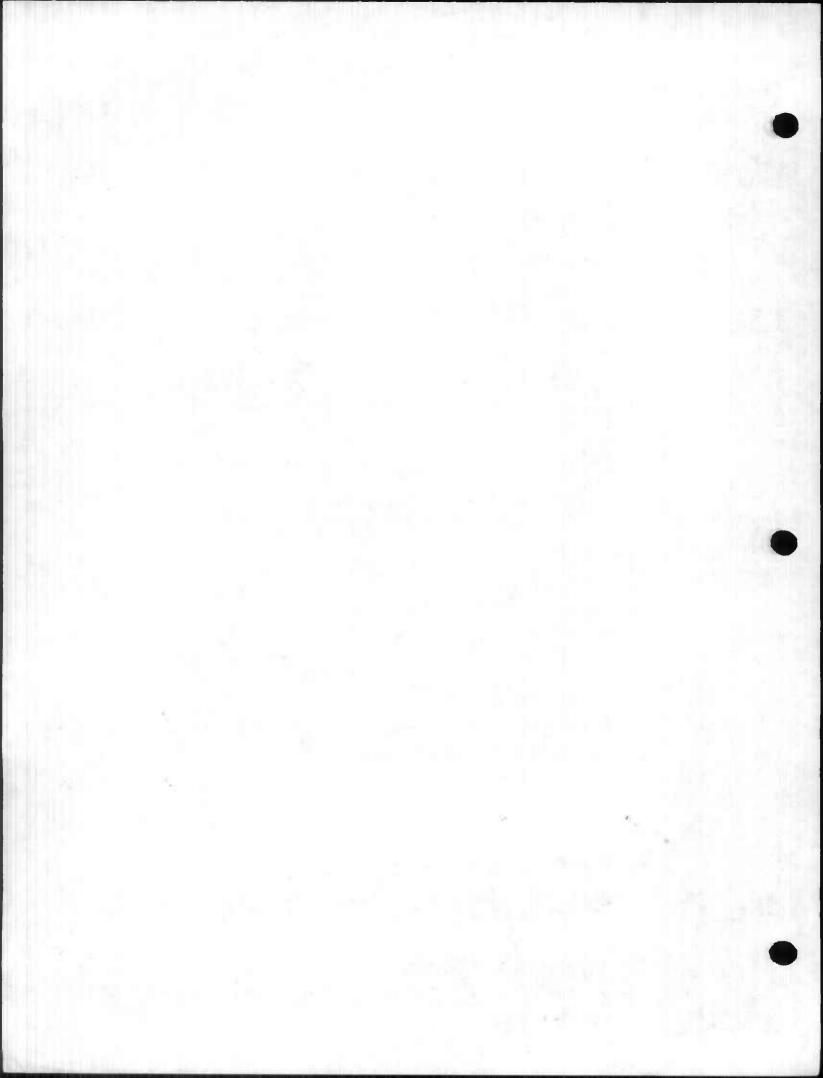
MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 21, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month 013 10, m 2000 119 /Medical 4e. Eacllity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County, of Death Examiner 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthdey) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 81 Director /127-07-3823 April 26,1919 New York 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Rems 23a or 28a-f show ther must be notified at Ellicott City Director 1 ☐ Yes 2 ☐ No Howard 10e. Street and Number 10g. Citizen of Whet Country? 5330 Dorsey Hall Funeral Drive 21042 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. The Medical Examiner filed within 72 hours efter 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 21215-0020 ò 1 ☐ Yes 2 ▼No Completed by 3 ☐ Widowed 4 ☐ Divorced Specifywhite "natural", 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry than Elementary/Secondery (0-12) College (1-4or 5+) Hygiene. Bank Officer Banking permit. Pages 1 end 2 should be life Department of Health and Mentel Hy, Important: If item 27 is marked others eny Injury or others. Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme, Be Arthur Kraus Anna Siebert 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Numbar or Rural Route Number, City or Town, Steta, Zip Coda) 5330 Dorsey Hall Drive Mary Kraus- Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 8-22-2000 Beltsville, MD. Chesapeake Crematory 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility m00741 1630 Edmonson Ave. Lemmer Witzke Funeral Homes, Inc. and Intl. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory and incl. on sville, nock, or heart tailura. List only one cause on each lina. **Physician** /Medical Immediete Causa (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Disaesa or Injury thet initieted events resulting in daeth) Lest Due to (er as e consequence of) P.O. Box 68760. Due to (or es e consequence of): USB BS s certificate has been signed by the a director, page 2 should be deteched to Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Records, by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings avelleble prior to Completed completion of cause of death? 2 NO 1 ☐ Yes 2 ☐ No After this certificate Division of Vital or Attending Physician: Be 25. Wes case rafarred to medical 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To the funeral 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Panding Investigation 1 Neturel s efter death. 2 Accident 6 Could not be detarmined 3 Suicide 28e. Pleca of Injury - At home, term, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) illed in by 4 Homicide Medical 29e. Certifier 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et tha tima, date end pleca, end due to tha ceuse(s) and mannar as stated.

2 Medical Examiner: On the bests of exeminetion end/or Investigation, In my opinion, death occurred et the tima, date end place, and dua to the ceuse(s) and mennar stated.

To the Hospital o within 24 hours of To the Funerel Di

31. Date filed (Month, Day, Year) State Registrar

29b. Signetule and title of certifier

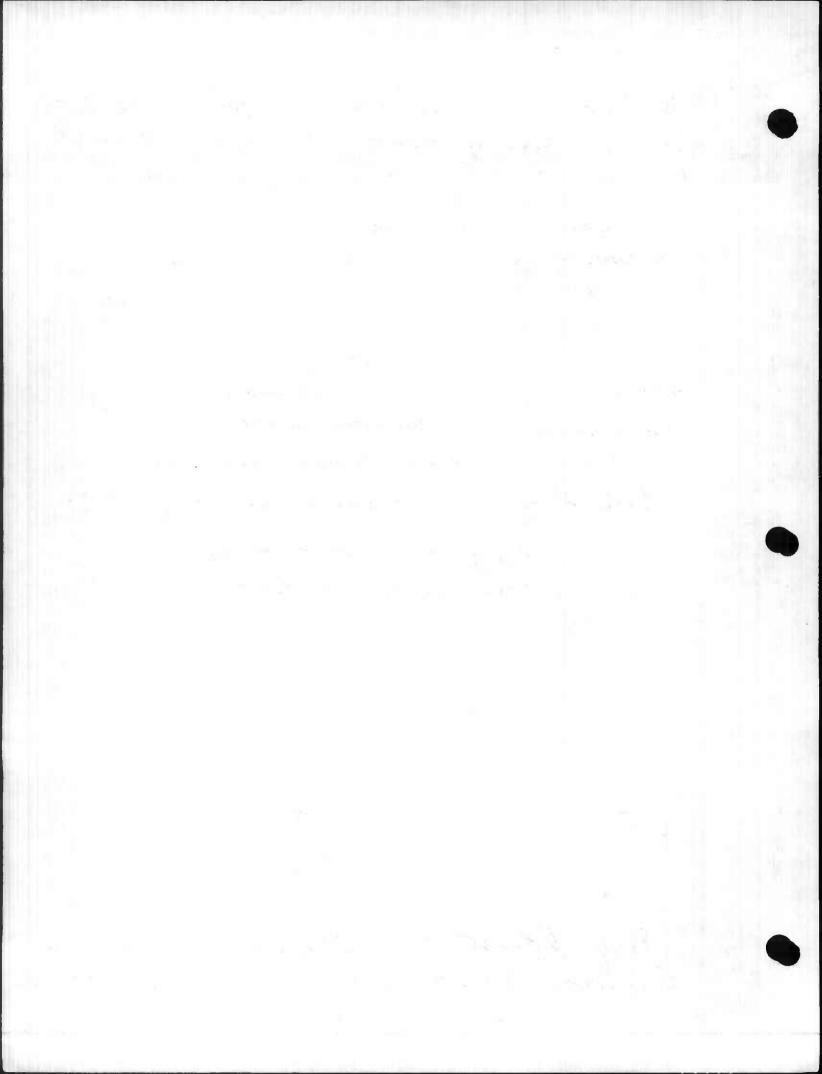
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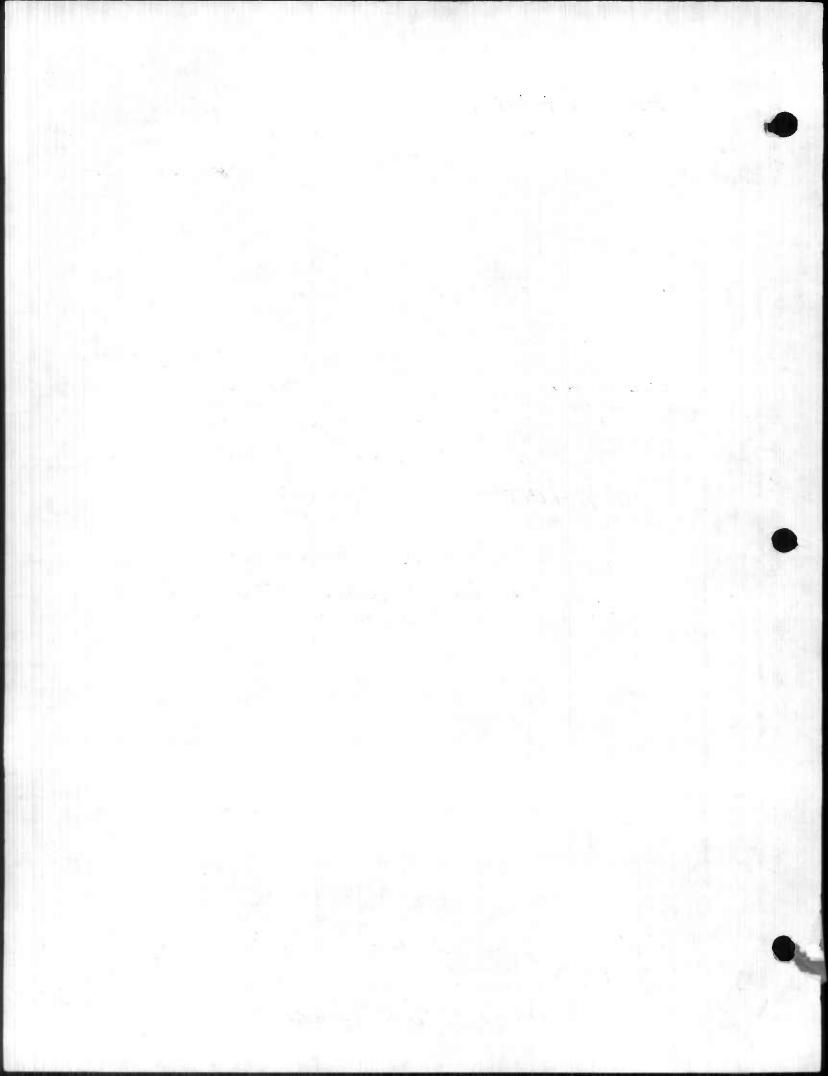
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29c. License number

29d. Dete signed (Month, Day, Year)



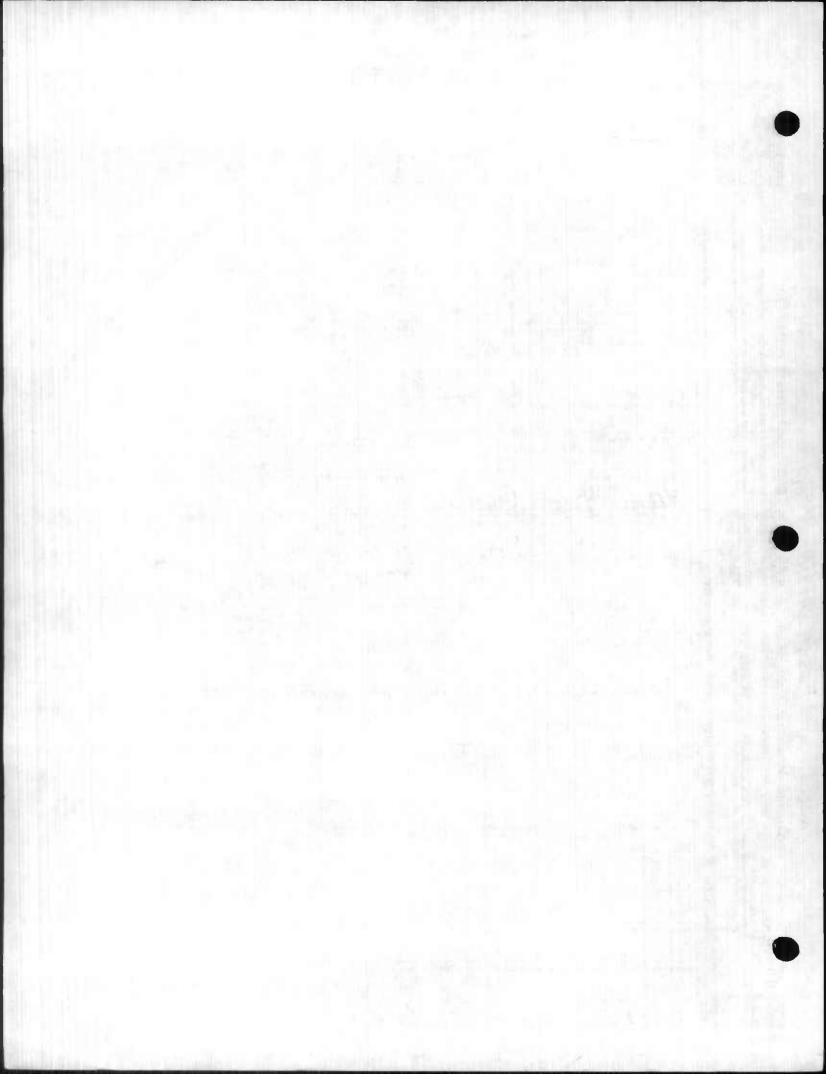
State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #1 PER MD G787 9/8/00 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM GEORGE KEINER JR. Year Month **Physician** 4b. City, Town, or Location of Death 4:00 AM 2000 12 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 8414 Snowden Loop Court Prince George Laurel If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) JAN. 15, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 161-30-5324 1♥M 2□F 64 Yrs. Pennsylvania Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location t0d. fnside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Prince George Laurel 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8414 Snowden Loop Court 20708 USA "natural", or items 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Agned Forces? Acmed Forces r 1 Yes 2 No 1955-If Yes, Give 63 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Peges 1 and 2 should be filed within nant of Heelth and Mentel Hygiene.
mt: If Item 27 is marked other than ", any or other traumatic event, me. Hes Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager / Supervisor 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Flichthorn William G. Ketner 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20708 Frances Ketner - wife 8414 Snoden Loop Court, Laurel, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department important: If eny injury or Baltimore Washington Cr. Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Fleck Funeral Home the 7601 Sandy Spring Road, Laurel, Md. 20707 inf. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ick, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in death) Examiner Examiner hysician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Box 68760. physician Physician/Medical Due to (or as a conseque 8.8 980 Po 23b. Dfd tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 94 Records, P.O. 20 No 3 Probably 4 Unknown signed by b 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen : hes page 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Attending 5 Pending investigation or Attending after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suiclde 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) g completed cause of death (Item, 23a) (Type, Pyint) 32. Registra's Signature 2015 31. Date filed (Month, Dey, Year) State huu 2 3 Registrar



State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No.	0 26633
	5 1 1	Decedent's Name (First, Middle, Last)		2. Dete of De Month	eath Day	3. Tims of Deeth
	Physiciar /Medica	EVELVII I'LIA MAIAS		August		1:50 pm
	Examine	A	4b. City, Town, or	Location of Dee	th 4c. County	of Death
		Gilchrist Center	Towson		Baltim	ore
	Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. Ia	7 011			Birthplace (State or Foreign Country)
	Director	21.3 12 6002 1 M 2 T 78	Yrs. Months Days Hours Min.	December		Baltimore, Maryland
	P .	Usual Residence of Decedent				
	anylar ahow		Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28e-f ahow	Maryland Baltimore Balt	imore County			X
	€ 80 €	10e. Street and Number	10f. Zip Code		10g. Citizen of W	/hat Country?
	ath w	7405 Belair Road	21236		USA	
		11. Merital Status 12. Was Decedent Ever in U,S Armed Forces?	 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puer 	Specify Yes or Note to Rican, etc.)	0- 14. Race Blec	- American Indian, k, White, etc.
02	. 0	1 Never Merried 2 Merried 1 Yes 2 No	1 ☐ Yes 2 ☐XNo Specify:		Specify	17.14.
8	"netural", or its	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				witte
7	led within 72 ho lygiene. her than "naturi It, tra Mexical	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking	16b. Kind of Bu	siness/Industry
12	d within giene.	Elementary/Secondary (0-12) College (1-4or 5+)				
77	al Hygie other in vent, it	6 N/A II	busewife 18 Mother's Na	me /First Middle	Housekeepi , Maiden Sumam	ing-Own Home
a u	Mental H Mental H erked off				, maioon garrian	9,
2	should by marked marked marked		Clara D. 19b. Mailing Address (Street and Number or R		has City or Town	Centa Zin Cadal
Maryland 21215-0020	2000	19a. Informant's Name/Relationship (Type, Print) Gondon R Bennett (Son)				State, Zip Code)
	permit. Pages 1 and Department of Health Important: If Item 2.7 eny Injury or other tr pnca.		2713 Yrey Road White Hall	Date Date		City or Town, State
∂n. Baltimore,	8 4 4 0	ILI Buner 2 AU Cremation 3 Linemoval from State	ca of Disposition (Name of metery, crematory or other place)			
, ±	permit. Page Department of Important: If eny Injury or ence.		Crematory Inc. August 21	, 2000	Baltimore,	, Maryland
Bal	Department of the police of th	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lassahn Funeral Home	Tm		
20	40200	200 that chascan Chance	/401 Belair Road Balt:	imore, Ma	yland 2123	
-		23a. Pert1. Enter the disease, or complications that caused the death. shock, or heert feilure. List only one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiretory	arrest,	Approximate Interval Between
0	Physician	0	, ,			Onset end Death
8	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	t Concer			year
2	STANKS.	Due to (or	as a consequenca of):			0
~	icate be axecuted physicien end street transit	b				
2.	ifficate be assocuted g physicien end as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or a	as a consequence of):			
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2 88	g physicate as the t	resulting in death) Last	is a consequence of):			
Light Box	(in C) (ii) ma					
3 8	sten: The law requires that the death cert entiticate has been signed by the attendin actor, page 2 should be detached for use Be Completed by Physician M			005 DI-	14-6	
0.	the d	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part i.		1	ntributs to the causs of death?
<u> </u>	that that ded by deta			1	Yas 200 No	3 Probably 4 Unknown
Sp	een sign hould be			24a. Wa	s an autopsy	24b. Were sutopsy findings
3 8	beer should			per	ormed?	available prior to completion of cause of death?
Recor	has to				v. altri	
<u>a</u>	iclen: The lay certificate has rector, page 2	OF Was seen adamed to medical			Yes 20 No	1 Yes 2 No
VItal	Physicien: this certific ral director,		Other	ath (Check only		1. H. 5.4.2-
35	Physic this contains rail dire		Proutpatient 3LI DOA 4LI Nursing I	Home 5 Res	how Injury occurr	er (Specify) TDSpice
7 5	Attending Physicien: The is refeath. ector: After this certificate he by the funeral director, page	27. Manner of Death 1 Autral 28a. Dete of Injury (Month, Day Year)	18b. Time of lnjury at Work? M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
100	death death stor: / y the f	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of thiury. At hor	ne, farm, street, factory, offica	28f. Location	(Street and Numb	er or Rural Route Number,
Division	74 = E	4 Homicide determined building, etc. (Specify)	and the state of t	City or To	own, State)	
	ours ours filled	29a. Certifier 1 Certifying Physician: To the best of my know	edne death occurred at the time, date and place	a and due to the	cause(s) and ma	nner as stated
	To the Hospital or Attending Pr within 24 hours efter death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examiner: On the basis of examination one)	n and/or investigation, In my opinion, death occ	urred at the time	, date and place,	and due to the cause(s)
	omplo the	29b. Signature and Alexandron / / /	29c. License number		29d, Date signed	d (Month, Day, Year)
	F > F 0	A Challemakeles	cus 025235		Arigu	d 20, 2000
		30. Name and address of person who completed cause of death (16fn			1	
	Q		5701 N. Charles	St. Be	les ,	nd 2120x
7	State	31. Dete filed (Month, Day, Year) 32. Registrar's Signatu				
K	Registrar	AUG 2 3 2000 Server &	Soork			
4			1			

ORIGINAL



B.K.S

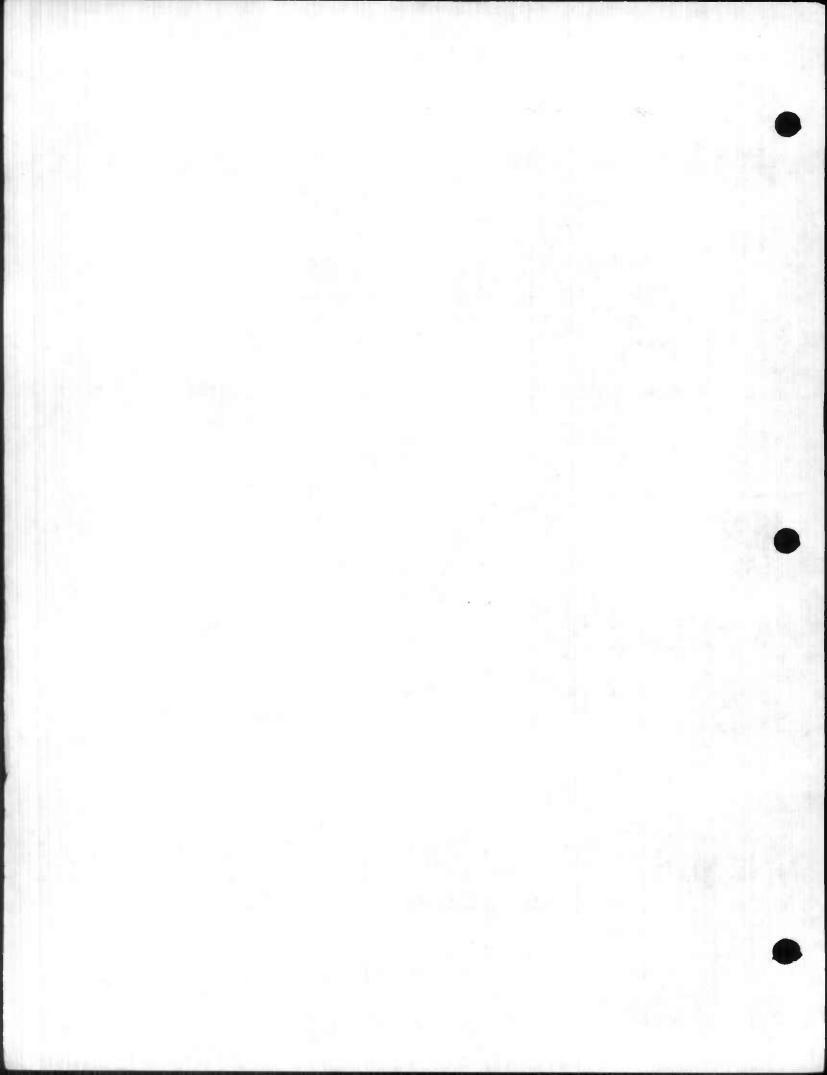
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

MARVIN E. LITTLE

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

M	ARVIN E.	L	ITTLE		State	ı ıvıaı			tificate o		eaith and iv D <i>eath</i>		Reg. No.)0	26634
	144.	-	1. Decedent's Name	(First, Middle, L	ast)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physiciai /Medica		MARVI	N I	EDWARD	Ι	ITTLE					AUG.		000	0539 AM
	Examine	_	4a Facility Name (#	not institution, gi	ve street and nu					4	b. City, Town, or Lo		4c. Cour	nty of Death	
			4992 P	INTAIL C	OURT						FREDERIC			DERICK	
	Funeral Director		5. Social Security No. 216-62-18	28	Sex 1∭MM 2□ F	7. Age (In yrs. lest birtl	rs.	Months Da	ear	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAR 2	Y. Year) 1 1955		place (State or Foreign ntry) ARYLAND
	pu *	1	Usual Residence of 10a, State	Decedent 10b. County		1	Oc. City, Town	or Loc	ation	_					t0d. Inside City Limits
	ith with the Marylar 23e or 28e-f show ist to notif ed at	5			TCV					,					1 ☐ Yes 2(X)No
	the production of the producti	Director	MARYLAND 10e. Street and Num	FREDE	KICK			rki	EDERICE 10f. Zip Coo				10g. Citizen o	of What Cou	intry?
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	ter death	Funeral	11. Mentel Stetus	TIMINIII	12. Was Dec	edent Ev	er in U,S.	13. W	as Decedent	of Hi	ispanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No-	14. R	lace - Americ	
21215-0020	S	2	1 Never Marrie		1 Tes If Yes, Gi Year or D	2 X No			☐ Yes 2KD		Specify:	riodii, oto./	Spec		
5-0	72 hours "netural",	Completed	/Sneci	15. Decedent's E	ducation		16a.	Decede	ent's Usual Oc	ccupa one o	ation during most of work	in <i>a</i>	16b. Kind of	Business/In	idustry
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9	Health Hem 27 other tr	-	20a. Method of Disp		locher		20b. Place of	Dispos	ition (Name o	of		Date DA	20c. Locatio		
Baltimore,				©Cremation 3 5 ☐ Other (Spec		State			etory or other EMATORY			-22-00	DATMT	MODE	MARYLAND
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Ö	Depa Impo		15	11/1							BROWN CO		FUNER	AL HOM	ME PA
		+	28a Part1 Enter the	6 dispase, or cor	nplications that	caused th	ne death. Do n				g, such as cardiac		rest,		Approximata
	Physician		shock, or hear	t fallera. List ont	y one cause on e	each line.	11								Interval Between Onset and Deeth
	/Medical		Immediate Ceuse (F	Finel			ton	al	NE						
н	Examiner		resulting in death)		8.	Di	ue to (or as a c	onsequ	uenca on:						
	p z	Examiner			b									1	
	cate be assected physician and sthe burial-transit	Xar	Sequentially list con	nditions, mediate		Di	ue to (or as a c	onsequ	uenca of):						
68760,	cate be ay physician the buria	- L	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or I that initiated events	rlying Injury	c									1	
687	O 0 0	edicai	resulting in death) L	ast		Di	e to (or es a c	onsequ	enca of):						
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m	iras that the death certifications signed by the attending to be detached for use a	Physician/M	Pert II. Other signification	cant conditions	contributing to d	eath but	not resulting In	the un	deriving caus	e aiv	en in Part I.	23b. Dld	tobacco use	contribute '	to the cause of death?
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Vital	s certificate director, pag	Q Q	25. Was case referr examiner?	ed to medical	Hospital:					Oth	26. Place of Deat		**		AM CODAID
of			1X Yes 2 □ ! 27. Menner of Death		10	Inpatient of thiury		-			4 LI Nursing Ho	me 5 Resident			Sity) AT SCENE
	ding h. After fune	Certification:	1 Netural 2 Accident	5 Pending investigation	28a. Dete (Mor	th, Day 1	rear) Ir	jury	28c.	Worl		Cod 4	+6	6	doelf
Division	or Attending after death. Director: Afte d in by the fune	1108	3 Suicide	6 Could not determine	ha -	of Injun	/ - At home, fai (Specify)	m, stre	et, factory, of	fice	- //	28f. Location (Street and Nu	mber o Rui	ral Route Number,
ă	a afta	Le L	4 Homicide		DUING	ing, etc.	(Specify)	es	iden	re	2	1992	Pint	211 Gt	- 21703
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	To To Com	Σ	29b. Signature and	title of cartifier	0	9	17.38				e number		29d. Date sig		
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	State Registra		AUG 2 3	2000	he 32.1	registrar	s Signature	1							
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 26635 Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Month Year MARKIEWICZ REGINA 18, 2000 1500 August 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Baltimore Samaritan Hospita. N/A 8. Dete of Birth (Month, Day, Year) Sept. 3, 1912 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign. Days Months Hours 1□M 2K)F Maryland Yrs. 213-03-3575 87 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d Inside City Limits ₩ Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 4237 Nicholas Avenue 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Anthony Kolasinska Maryann Niepieralski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Mary Jane R. Markiewicz (Dghtr) 4237 Nicholas Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cametery, cremetery or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22/00 Baltimore. Maryland Holy Rosary Cemetery 22. Name and Address of Facility
Schumunek Funeral Home Inc. 21. Signeture of Funeral Service Licensee Mark T. Zaza 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease properties that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediate Causa (Finat disease or condition resulting in death) ARREST CARDIAC Corona ry
Due to (or as a consequence of): arteru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 X No 25. Wes case referred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 DiNetural 5 Pending investigation 1 Yes 2 No 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

than "natural", or hama 23e or 25e-f el the Medical Examiner must be notified

filed within 7 Hygiens.

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permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any Injury or other traum

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

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Director

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Examine Physician/Medical by Completed Be 10

burial-transit and physician a 980 the signed by t d be detact peed page 2 (certificata this funeral Certification:

certificata be n 24 hours after death.

Ne Funeral Director: After the pletely filled in by the funeral or Attending Hospital To the Hosp within 24 hou To the Fune completely fi

State Registrar

edicai

29b. Signature and title of certifier Bichhum 11.

6 Could not be

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Junh, MD

29c. License number -005 499 G 29d. Date signed (Month, Day, Year) 18,2000

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bichhuong 5601

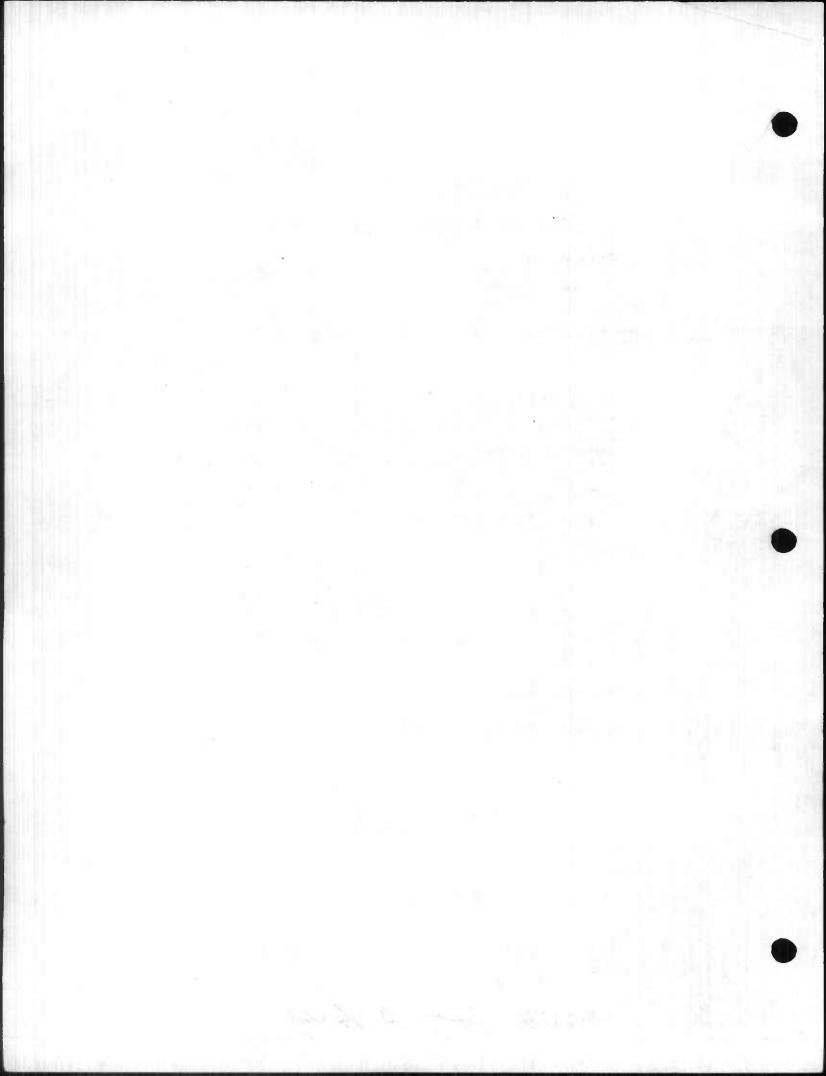
M. Pinh, MT 31. Date filed (Month Day, Year) 32. Registrar's Signature

AUG 2 3 2000

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Raven Blud, 3rd Floor, Baltimore

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

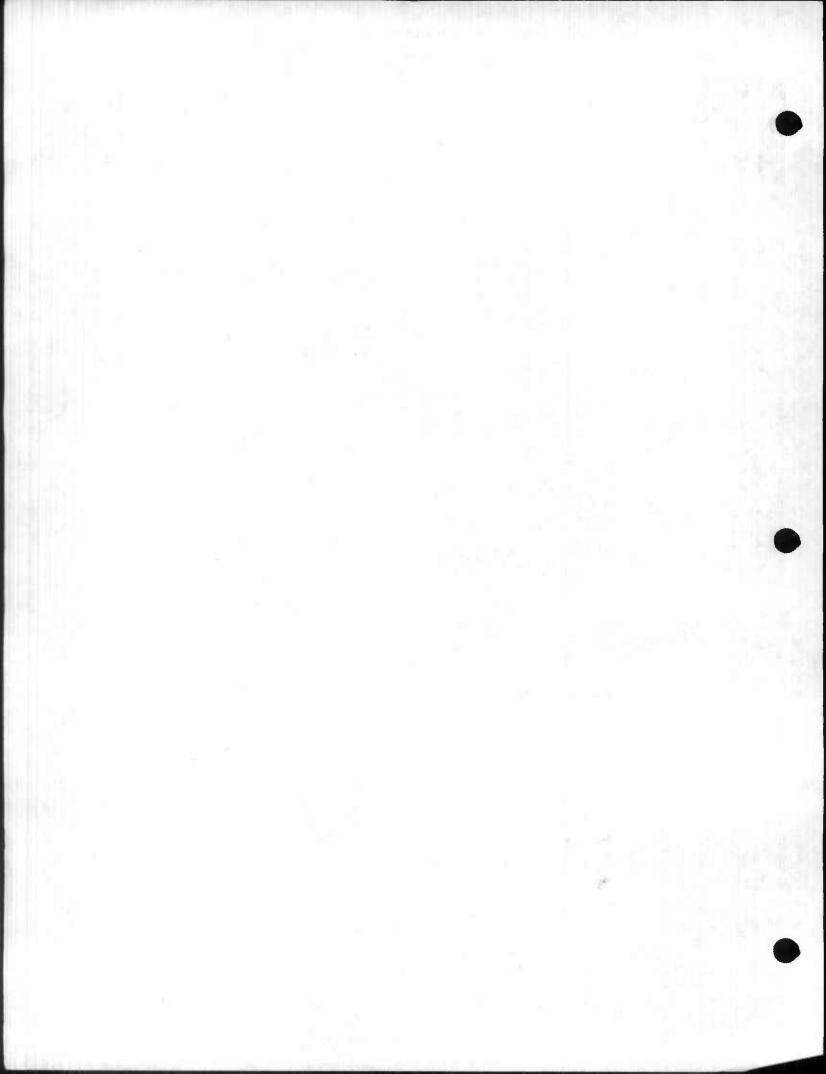


State of Maryland / Department of Health and Mental Hygiene

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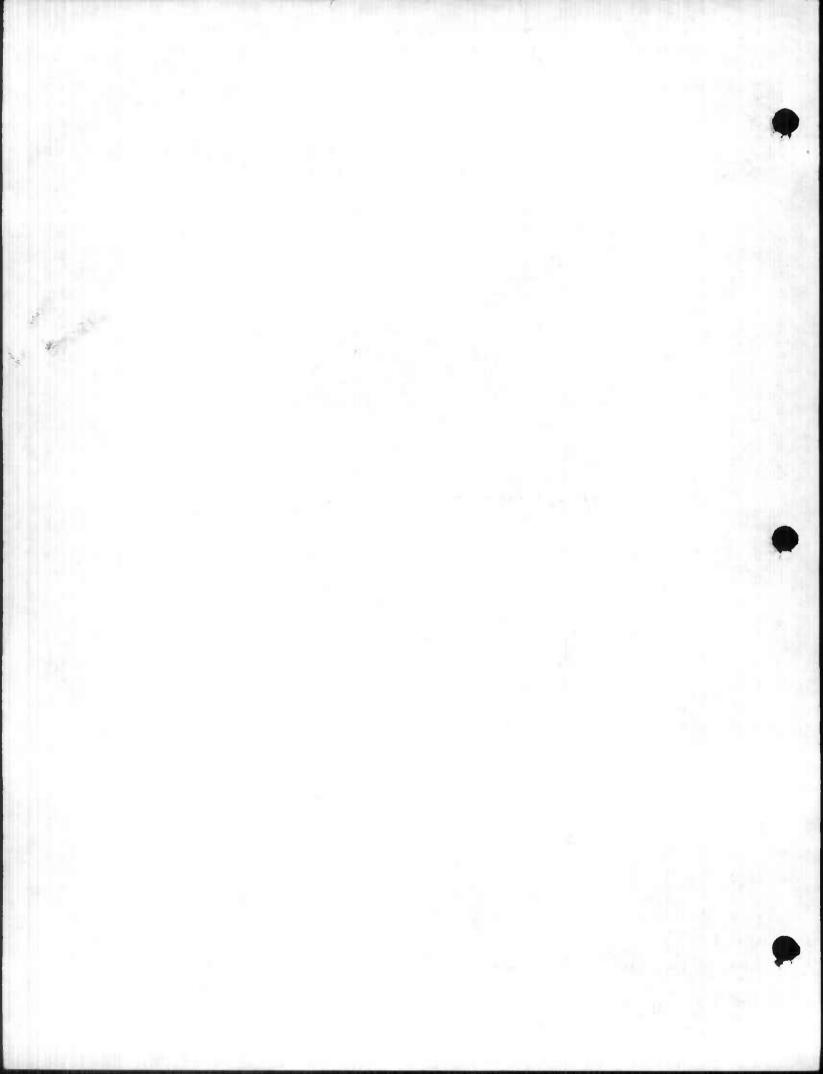
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	Physician /Medica	IR		G . MANUE								2. Date of De Month July	Day	Year 2000		54 A.M
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					mount A		1st flo		lav d Vans		ltimo			N/A		
	Funeral Director	5. Social S UNK			3. Sex 1 □ M 2 1 F		s. last birthday)	Month	ler 1 Year s Days		Min.	8. Date of Bir (Month, Da unk	ny, Year)	9. Birthp Coun	-	ate or Foreign
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1215-	ed within 72 ho yglene. er than "nahun 4, the Medical J	Element	ary/Seco	15. Decedent's ify only highest of ndary (0-12)	grade completed	(1-4or 5+)	16a. Dece (Give life.	dent's Us kind of v DO NOT	vork done use retire	aduring most of working ad)		16b. Kind of B	usiness/inc	dustry		
5	A STATE OF	unl				unk		ι	ınk	10 Mather's Name /First Middle Mai				unk		
Maryland 21215-0020	Mental H Mental H srked off stic even		s Name (First, Middle, La	ist)					18. Moth	er's Name (First, Middle, Maiden Sumame) unk					
	and 2 sho alth and 1 27 is ma ir trauma	19a. Inform	mant's Na .M.E.	me/Relationship	(Type, Print)			-				imore,	MD 212		Code)	
Baltimore,	ages 1 a ent of He ht: If Item y ov othe	20a. Metho	urial 2[□Removal from		Place of Dispo cemetery, cre	osition (A matory o	lame of r other pla	nce)		Date	20c. Location	- City or To	wn, Stat	a
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ğ	death e atten ed for u	Bad II Oth	e elenid	sent conditions	a contribution to	dooth but only	aculting is the .	ng in the underlying cause given in Part t.				23b. Did tobacco use contribute to the co			the ear	uon of death?
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0 00	After After fune		turel	5 Pending investigat	(Mo	e of Injury onth, Day Year)	28b. Time of tnjury	M		ury at ork?] Yes 2 □		Home 5 ☐ Residence 6 ☑ Other (Specify) 28d. Describe how injury occurred				
5	tal or Attending P rs after death. al Director: After t led in by the funer Certification:	3 □ Su 4 □ Ho		6 Could not determine	ad 200. Plac	ce of Injury - At ding, etc. (Spe	home, ferm, st	reet, fact	ory, office			28f. Location City or To	(Street and Num wn, State)	ber or Rura	il Route	Number,
	To the Hospital or Aften within 24 hours after deat To the Funeral Director: completely filled in by the Madical Certifica				Physician: To the and ma											ise(s)
	within To the		ture and	itle of certifier	1			2	9c. Licen	se numbar			29d. Date signe	ed (Month,	Day, Ye	ar)
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				EM, K	no completed call	use of death (It			n St	reet,	Balt	imore.	Marylar	nd 21:	201	
	State	21 Data fil				Registrar's Sig		in	-	eks.						



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TAMES	MITAN AMEND	TITEMS #73	DADT T	TT	Department of Health and I Certificate of Death	9-1-00 WR.	
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niner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or L				
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al or	UNK	9X 7. Age (In y	rs. last birthday) Yrs.	Months Deys		8. Dete of Birt (Month, De) Jan 28,	t, Year) 1961	Country)	(State or Foreign unk
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Director	MD	N/A	В	altimore					Yes 2□No
	10e. Street and Number 4000 Fords Lane	Apt 2D		10f. Zip Code	21215		10g. Citizen of V	130	
by Funeral	11. Meritel Stetus unk 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes:		Vas Decedent of Yes, specify Cut ☐ Yes 2 No	Hispanic Origin? (Speen, Mexican, Puarto	pecify Yas or No- Rican, etc.)	Bled	SA e - Amarican II kk, Whita, atc. black	
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100	19e. Informent's Neme/Reletionship (7 O . C . M . E .	ype, Print)			tend Number or Ru eet Balt			_	de)
	20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify	Removel from Stete	o. Plece of Dispos cematery, crem	sition (Neme of netory or other pla	900)	Dete	20c. Location -	City or Town,	Stete
	21. Signature of Fundral Service Licen Bonald S	Wade Direct		Name end Addr State An Baltimor	ess of Facility atomy Boar e, MD 21	rd 655 201	W. Balt	imore :	Street
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edical Ce	29a. Certifier 1 Certifying Phy (Check only one) Medical Exam	relofen: To the best of my liner: On the basis of examend menner steted.	knowledge, deeth ination end/or inv	occurred et the t estigation, in my	ime, dete end plece opinion, death occu	, end due to the rred et the time,	cause(s) end me date end plece,	enner as stated	d. e ceuse(s)
X.	29b. Signature and titla of certifier			29c. Licer	se number		29d. Date signe	d (Month, Dey	, Year)
	· Clerning (Chelen			C.M.E		AUG.	8, 200	0
	Dennis Chute	completed cause of deeth (, Baltimo	re, Mar	yland 2	1201	

Registrar

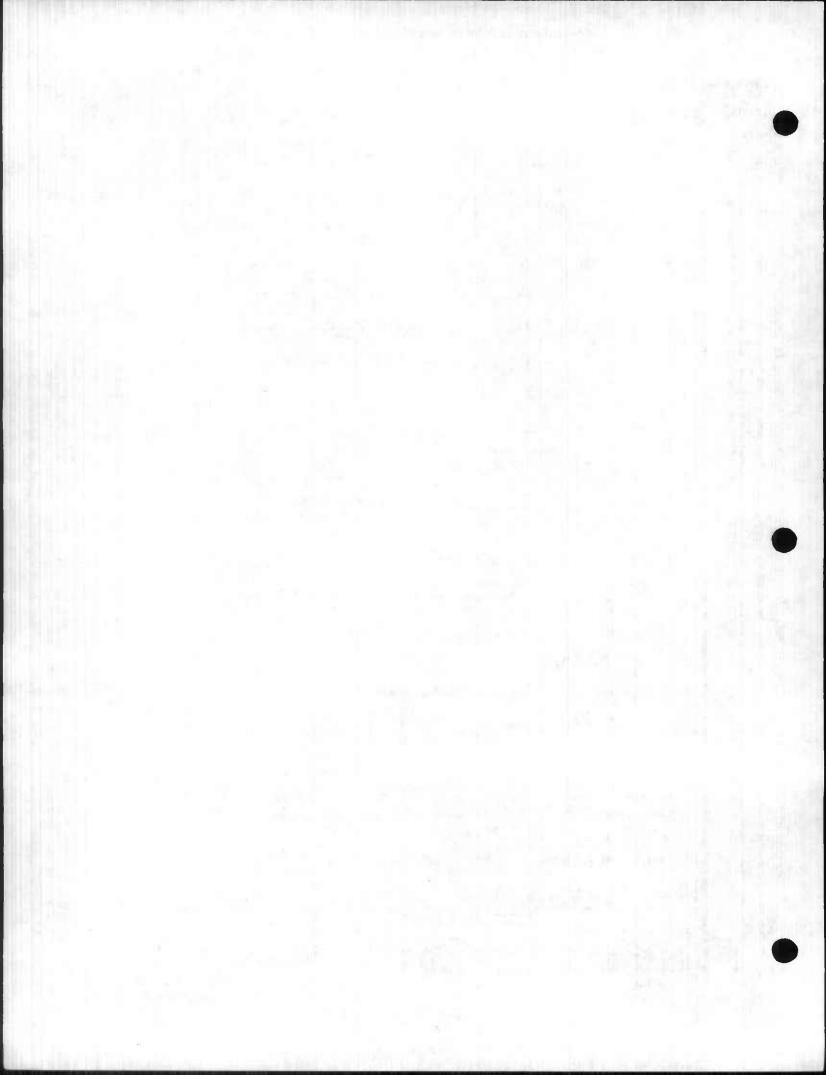


State of Maryland / Department of Health and Mental Hygiene 0 0 26638

Decodering Name (First, Meddin, Last) Arriance Teaching Name (First		Certificate of Death	Reg. No.	
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## A CORP / TOWN of Caches of Management of Control of Secretary Control of Secretary		MARJORIE T. MURPHY		
S. Social Sociality Number Social Sociality Number California C		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		
5. Social Security Number 5. Social Security Number 6. See:		Mariner Health Care Catonsvill	e Bal	timore
215-30-5243 216-00my 105-00my 105	Funeral	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		
Usual Reaction of December 100 Colly, Town or Location 101 Indeed City L 10 Indee	Director	I I W ZU F Vre		
The street and flumber 10		Usual Residence of Decedent		
15. Decadent's Education (Specify only highest granted competed) 16. Decadent's Usual Occupation (Give and only groot dry ending most of working groot gr	ms 23a or 28a-f ahow rmant to notified at neral Director	10a. Stata 10b. County 10c. City, Town or Location		
15. Decadent's Education (Specify only highest granted competed) 16. Decadent's Usual Occupation (Give and only groot dry ending most of working groot gr	ct of		11e, Md, 21228	X X
15. Decadent's Education (Specify only highest granted competed) 16. Decadent's Usual Occupation (Give and only groot dry ending most of working groot gr	or 2	10e. Street and Number 10f. Zip Code	10g. Citizen	of What Country?
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15. Decadent's Education (Specify only highest granted competed) 16. Decadent's Usual Occupation (Give and only groot dry ending most of working groot gr		11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Maxican, Puerto	ecify Yas or No-	
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Secretary 15	d b	3 ☐ Widowed 4 ☐ Divorced Year or Datas:		
Secretary 15	ote of	(Specify only highest grade completed) (Give kind of work done during most of work	ting 16b. Kind o	f Business/Industry
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Harold Burns, Jr. 20. East Lexington St. Suite201, Balto. Md. 212/ 20. Method of Disposition Security Date 20. Location - Chy or Town, State	d out		e (First, Middle, Maiden Sun	neme)
Harold Burns, Jr. 20. East Lexington St. Suite201, Balto. Md. 212/ 20. Method of Disposition Security Date 20. Location - Chy or Town, State	Mer To			
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Modical aminer Part III Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.		23a. Part Enter the disease, or complication that caused the death. Bo not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	vsician	secon, or near taxura. List only one gause on each line.		Onset and Death
Part II. Other algnifficant conditions contributing to death but not resulting in the underlying cause given in Part I. Due to (or as a consequence of):	Medical	tmmediate Cause (Final		1/2
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24a. Was an autopsy finding available prior to completion of caus of death? 1 Yes 2 No 1	y the			
available prior to completion of caus of death? 25. Was case referred to medical examinar? 1 Yes	y P	Hx CVH	1 T86 2 L	10 3 Frobably 4 Gronks
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2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signalure and title of certifier 29b. Signalure and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	uner	1 ØNatural 5 ☐ Pending (Month, Day Year) Injury Work?	200. Describe how injury of	ccurred
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated (Check only one) 29b. Signalure and title of certifier 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 22, 24	Se le C			
and manner stated. 29b. Signs in a and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 22, 20	cal cal	(Check only 2 Medical Examiner: On the basis of examinetion and/or instigation, in my opinion, deeth occur	and due to the cause(s) and red et the time, date and ple	manner es stated ce, end due to the ceuse(s)
29b. Signal wand title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 22, 20	the f	and manner stated.		
2 164cm mg D 5674 L Hugust 22, 20	To	29b. Signal 19 and title of certifier 29c. License number	29d. Date si	
	22	Byon mo D3674	- Huge	M 24,20
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. TIRAKHIA MA 1809 Frederick Rood. Cotonsville, MD 21228	(1"/7)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, ,,,	110 0 1200
B.TURAKHIA Mp. 1009, Frederick Rood. Catorsville, My 21278	th !			
State State 31. Date filed (Month, Day, Year) AUG 2 3 2000 32. Redistrar's Signature Segistrar State State AUG 2 3 2000	(4)	B.TURAKHIA MD. 1009, Frederick Rood. Ca	torsulle,	1. d) C1778

State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate	of L	Death		Reg. No.	U	200	39	
			1. Decedent'a Name (F	irst, Middle, Las	st)						2. Dete of De	ath		3. Time	of Death	
	Physici		Edward Fre	derick	McCubbin						Month	17, 200	Year) ()	6:27	am	
	/Medic Examin		4e Fecility Name (If no	t institution, giv	e street end number)	In ell			4	b. City, Town, or L						
W.			5535 Channi	ing Road	d				В	altimore		Balt	imor	e		
Г	Funeral		5. Social Security Numi			e (In yrs. le	ast birthday)	If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De	h Veerl	9. Birth	place (Stete intry)	or Foreign	
П	Director		218-22-2167	7 2	M 20 F	72	Yrs.	MORERS	Deys	Hours Will.	Dec. 29			yland		
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	anylar show	_		b. County		10c. City	, Town or Lo	cation						10d. Inside (
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	after death with the Maryland or Items 23s or 28s-1 show in set must be noursed at	Funeral Director	5535 Chan	ning Ro					229			USA				
	to Trade	une	11. Merital Status		12. Wes Decedent Armed Forces?		5. 13. V	Vas Decede f Yes, specif	nt of Hi fy Cube	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)		e - Ameri k, White	ican Indian, , etc.		
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	tal Hygid d other event, ti	0	17. Father's Name (Fir:	st, Middle, Last)				701		18. Mother's Nem	e (First, Middle,					
Maryland	0 2 0	To Be	Nicholas	O. McCu	bbin					Margare	t Burl					
37	SEE		19a. Informant's Name	/Relationship (Type, Print)		19b. Mailin	ng Address (Street	and Number or Ru		er, City or Town,	State, Zi	ip Code)		
	C1 0 0 0		Bernardin	e J. Mc	Cubbin/Wii	Ee	5535	Chan	ning	Road, E	altimor	e. Marvi	land	21229		
re,	f Heelth fem 27 other tr		20e. Method of Disposi		No. (LIJA)	20b. Pl	ece of Dispo metery, cren				Date	20c. Location -				
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	/Medical		Immediate Cause (Findisease or condition	al	Au.	0 - 0			,		1		1			
	Examiner		resulting in death)		a. /190	7-10	es e conseq	271	1-1	grerro			- 1	FEW.	*.NJ183	
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	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, Due to (or as a consequence of): OSCA Diagram (Conditions)										CAST 10			
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68760,	ificate be execu g physician and es the burial-tran	ICa	thet initiated events	y	C	Due to (or	es e conseq									
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P.O. Box	w Attending Physicien: The lav ter deeth. Irector: After this cardificate has In by the funeral director, page 2	Medical Certification: To Be Completed by	25. Was cese reterred examiner? 1 Yes 2 No 27. Menner of Death 1 Naturat 5 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title	to medical Description of the conditions of the	d	ent 2 E	ER/Outpatien 28b. Time of Injury me, ferm, str.) riedge, deett on and/or inv	nderlying center and a pool of the state of	A Othor	26. Place of Dea 37: 4 Nursing H rat rat rat rat rat rat rat ra	24a. Was performent to the Check only of the Check only only only only only only only only	Yes 2 No an eutopsymed? Yes 2 No one) dence 6 □Oth how injury occur Street end Numb wn, Stete) cause(s) end me dete and place, 29d. Date signe	24b. V 24b. V 3 G G G G G G G G G G G G G G G G G G G	Nere autops: Validation of death?	Inknown Indings to cause	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey **Physician** Sadie D. Mott July 29 2000 0703AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Laurel Regional Hospital 5. Social Security Number If Under 1 Yeer 8. Date of Birth December 16, 1912 9. Birthplace (State or Foreign SOUTH Carolina 7. Age (In vrs. last birthday) **Funeral** Days 1 M 28 F Months Hours 87 Yrs. 249-30-4318 Director **Usual Residence of Decedent** 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f ahon ? Is marked other than "natural", or items 23s or 28s-f shot traumstic event, he Medical Eramine, mast be notified as Suitland Prince George's Maryland 1 No Yes 2 No Funeral Director å 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20746 2937 Sunset Lane death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2\(\frac{1}{2}\) No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Maritel Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mentel Hygiena. wrt: If Hem 27 is marked other than "neturel", or Nei 1 Never Married 2 ☐ Married 21215-0020 1 Yes X No Specify: by Specify: Black 3 NWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Domestic Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Phyllis Ready Brister Davis, Sr. 19e. Informant's Name/Relationship (Type, Print)
Miss Angela Davis (Grand-Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2937 Sunset Lane Suitland, Marry Land 20746 other 20b. Plece of Disposition (Name of cemelery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Gurial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or ò 8/5/2000 Greenpord, South Carolina Ebenezer Bapt. Church Cemetery □ Donetion 5 Other (Specify) e of Funeral Seryide License 22. Name and Address of Facility
ROLLINS FUNERAL HOME, INC. 4339 H.NT PLACE, N.E. WASHINGTON, D.C. t1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Aspiration -Preumonia Examiner Due to (or as a consequence of): Examiner Cerebrovascular Accident The law requires that the death certificate be associed burial-tran Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated exerts. pue Hypertension Box 68760, physician Physician/Medicai the that initiated events resulting in death) Last Due to (or as e consequence of) 50 080 Pert II. Other algorificant conditions contributing to death but not resulting In the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed After this certificate has 1 Yes 2 XNo 1 ☐ Yes 2 ZKNo Attending Physician: 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1XMatural death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi the 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier edicai 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) (Check only one) 29b. Signature and title of a 29c. License number 29d. Date signed (Month, Dey, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechi Fredokinara, md 6201 Greenbelt Road SuiteU75 COllege Park, Maryland 20740

DHMH 16 Rev 6/95

State

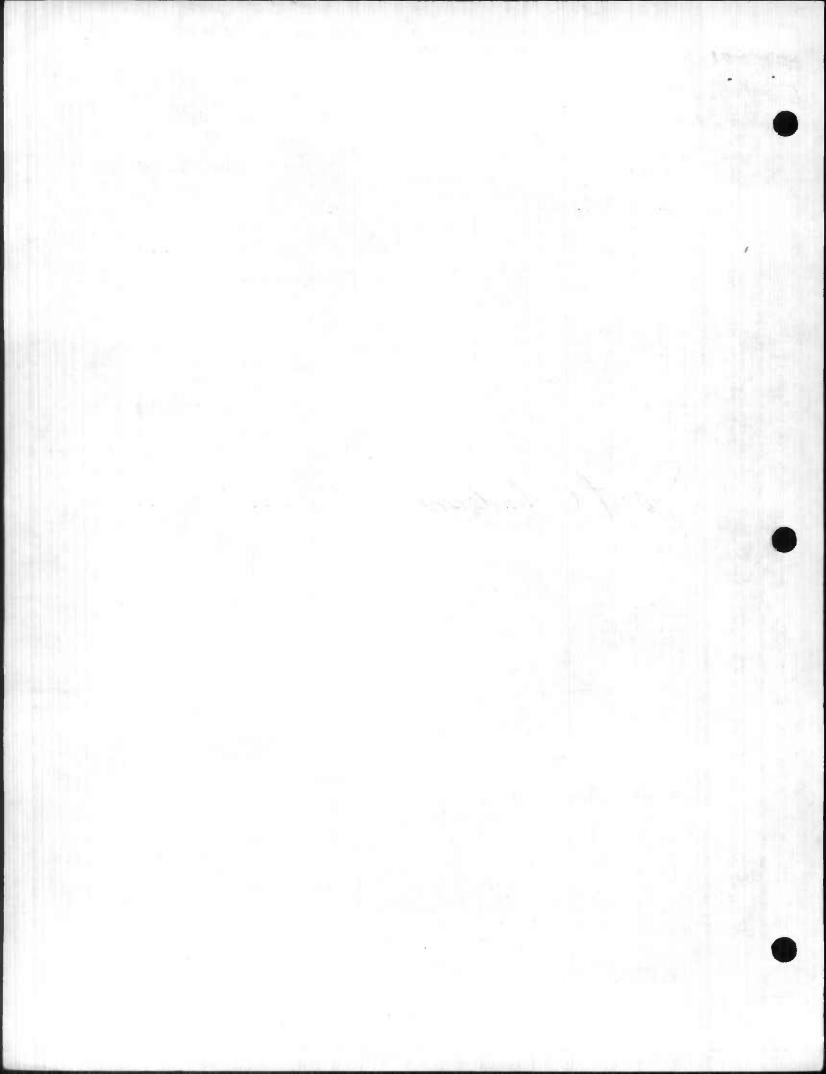
Registrar

31. Dete filed (Month, Day, Year)

UG 2 3 2000

ooks

32. Registrar's Signeture



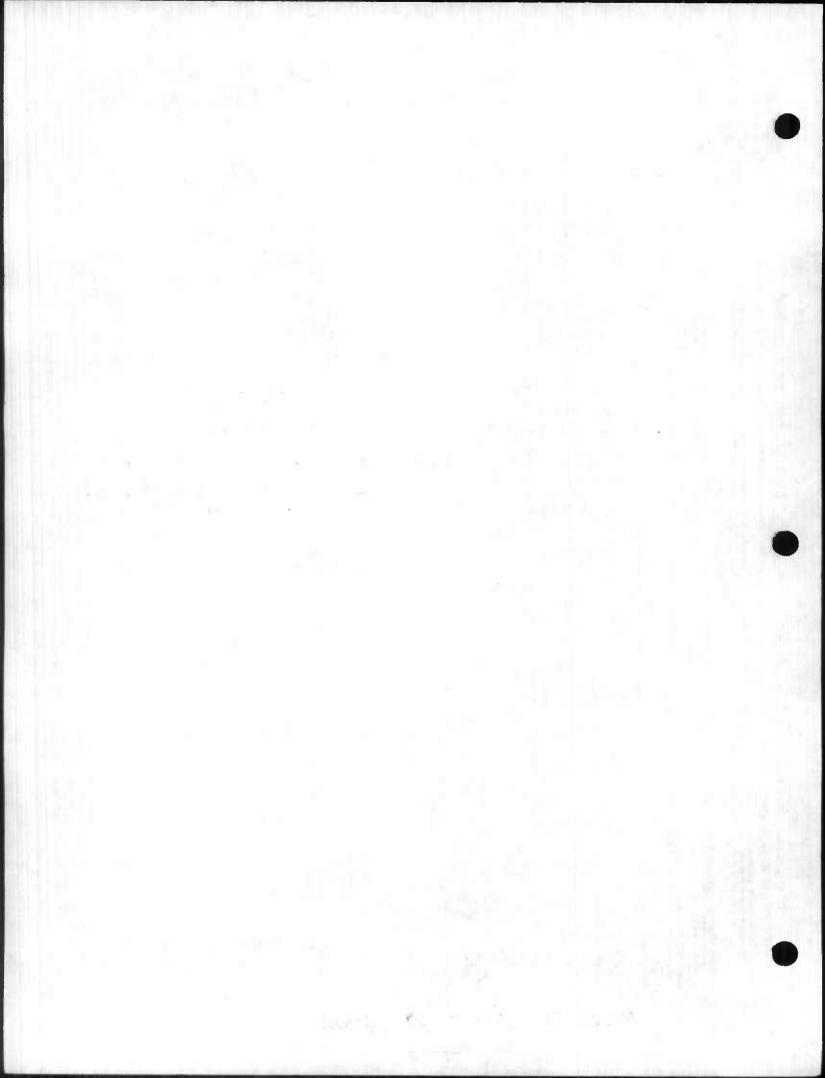
JOSEPH M. MCKENZIE

State of Maryland / Department of Health and Mental Hygiene

JVW AMEND ITEMS: #23 PART I, 27, 28A Certificate of Death

	Decedent's Name (First, Middle		, 2,1, 2	-OA_UE	runcate of	Dealli	2. Deta of De	Reg. No.		3. Time of Deeth		
sician edical		J		ichael	McKenzie		Month AUGU:			01:30 A.M		
miner	4a Facility Name (If not institution 1961 STEVEN D		number)			4b. City, Town, o	r Location of Deal	4c. County of Death HARFORD				
eral tor	5. Social Security Number 218-70-9196	6. Sax 1⊈M 2□1	1	s. lesi birthday Yrs.	Months Day		n. (Month, Di	rth ey, Year) 17,1957		place (Stete or Foreig ntry) ryland		
	Usual Residence of Decedent 10a. Stata 10b. County	,	100 (City, Town or L	ocation					10d. Inside City Limits		
uneral Director	Maryland	Harford	100.	oky, rown or E		Edgewood				1 ☐ Yes 2.8200		
Dire	10e. Streef and Number				10f. Zip Code			10g. Citizen of				
3	1961 Steven D					2104		United				
by Funer	11. Marital Sfatus 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 Yes	Dacedanf Evar in I Forces? as 251No Give or Datas:	U,S. 13.	Wes Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☐ N	Hispanic Origin? (ban, Mexican, Pue o Specity:	Specify Yas or Norto Rican, etc.)	Specil	ck, Whita,	can Indian, , etc. hite		
		nt's Education	Datas.	16a Dece	edent's Usual Occ	unation		16b. Kind of B	usiness/Ir	ndustry		
Completed	(Specify only highs	st grade complete		(Give	e kind of work don DO NOT use reti	e during most of w	orking	1001111110111				
E	Elementery/Secondery (0-12)	2 Ye	e (1-4or 5+)	Sect	urity Gua	ard		Sec	urity	7		
Be C	17. Father's Name (First, Middle,	Last)				18. Mother's N	ame (First, Middle	, Maiden Sumer	ne)			
ToB	Marshall Jose	ph McKen	zie			Vir	ginia	Harris				
-	19e. fnformanf's Name/Relations		15-11-	19b. Mai	Ing Address (Stre	et end Number or I	Ru <i>ral Route N</i> umi	ber, City or Town	Stete, Zi	p Code)		
	Mrs. Pam Kistn	er (Sist	er)	762	3 Cedar	Road Du	ndalk. M	arvland	212	22		
	20a. Method of Disposition	er (Drac		Pleca of Disc	osition (Neme of		Date	20c. Location				
	1 Buriel 2 Cremation Donation 5 Othar (5	3 □Removal fro Specify)	om State H.		Service	Corp. 8/	22/2000	Tows	on, M	laryland		
8	21. Signature of Funerel Servica	Licansee)	2	2. Name and Add							
8	Duda-Ruck Funeral Home of Dundalk, I 7922 Wise Ave. Dundalk, Maryland											
	23a. Part1. Enter the disease, o shock, or haart feilura. List	r complications th	at caused the de	eath. Do not er					na Z	Approximete Interval Between		
Wedical Examiner	Immediate Cause (Final disaase or condition resulting in death)	e		(or as e conse		XICATIO)N					
al Examiner	Sequantially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury	G	Due to	(or es e conse	equence of):							
vMedical	that initiated events resulting in death) Lest	d	Due to	(or es a conse	quenca of):							
iciai	Part II. Other eignificant conditi	one contributing t	o death but not r	esulting in the	underlying cause	given in Part I.	23b. Dio	I tobacco use co	ontribute	to the cause of deat		
by Physician							10	Yes 2□No	3 □ Pro	obably 4 Unkno		
Completed by								s an autopsy formed?	a	Vare autopsy findings vaileble prior to ompletion of cause f death?		
E							De	Yes 2□No	1	XYes 2□ No		
BeC	25. Was case referred to medical	al l		40%		26. Place of D	eath (Check only	one)				
0	examinar? 1 X Yes 2 No	Hospital:	☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA		Home 5□ Res		her (Spec	(V) SCENE		
tion: T	27. Manner of Death 1 Natural 5 Pendi	28e D	ete of Injury fonth, Day Year) 17-00	28h Time	of 28c. In		28d. Describe	how Injury occu		.,,,		
Certification:	3 Suicide 6 Could 4 Homicide determ	nof be nined 28e. Pl	aca of Injury - At uilding, etc. (Spe HC	home, farm, s city) ME	treet, factory, offic	Se		(Street and Numbers, State)		STEVEN D		
edicai (Examiner: On th				time, dete end ple y opinion, death oc	ce, end due to the	e cause(s) and n	anner as			
Medical Certification:	29b. Sopraturation dittle of certifie		no		29c. Lica	O.C.M.E	•	29d. Date sign AUGUS				
	30. Name and address of person 31. Date filed (Month, Dey, Year,	ocke,	ause of deeth (It	em 23a) (Type		et, Balt	imore, M	aryland	2120	1		

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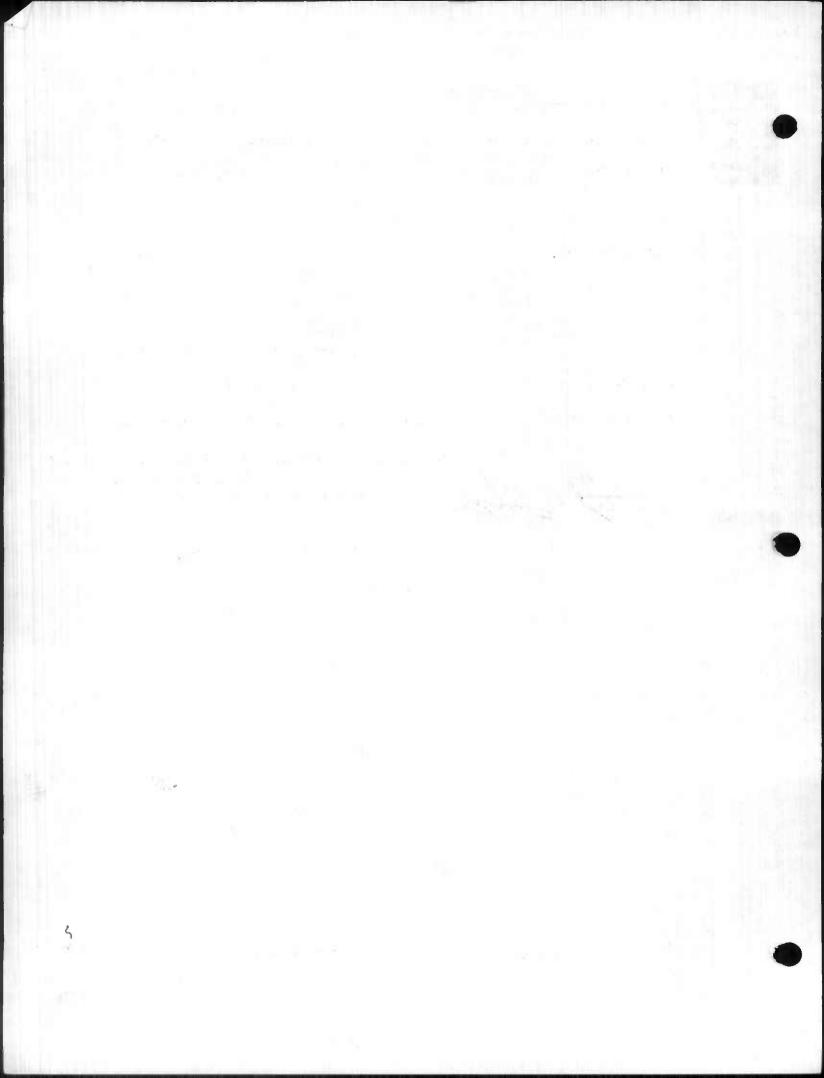


	ian	1. Decedent's Name (First, Middle, L.	I MALL LY IV	aymond Mun	ma		2. Dete of Deeth	J. No.	3. Time of Dear
Physic /Medi	cal	Harry Robert Mu			1-		August 2	2, 2000°	
Exami	ner	4e. Fecility Neme (If not institution, gi Lorien Frankfor				4b. City, Town, or Los Baltimore		4c. County of De	eeth
unerai irector		5. Sociel Security Number 6. 219-01-2960		ga (In yrs. last bir	thday) If Under 1 Year Months Days	Accession and the second second	8. Data of Birth (Month, Day, Y 2/13/191	(ear) 9. 8 4 Ma	sirthplaca (State or Fo Country) ryland
ta-f show	ctor	Usual Residence of Decedent 10e. Steta 10b. County MD N/A		10c. City, Tow Baltim					10d. Inside City Lin
23s or 20	ai Director	10e. Street and Number 3224 Lake Avenu	e		10f. Zip Code 212	213	100	U.S.A.	Country?
*natural", or flems 23a or 28a-f ehov parcal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yas 2 If Yas, Give Yaer or Detes:		13. Was Decedent of Hif Yes, specify Cub. 1 ☐ Yas ②□No		cify Yes or No- Rican, atc.)	14. Race - Ar Bieck, Wi Specify: W	
-	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	petion during most of working	ng 16	b. Kind of Busines	s/Industry
ther than ant, the Me	Comp	Elamentary/Sacondery (0-12)	Coilaga (1-4or		xecutive Sec			altimore	City
D A	To Be	17. Fether's Nama (First, Middle, Lass Henry C. Mumma				18. Mothar's Name Mary Emm			
Tage .		19a. informent's Neme/Reletionship Ronald G. Hartm	(Type, Print) an		Mailing Address (Street 208 Hunter (
met of the		20a. Method of Disposition 1 XBurial 2 Cremetion 3 E 4 Donation 5 Other (Speci		20b. Place of cemeter	Disposition (Neme of y, cramatory or other pleaned Memorial	ce)	Dete 20	c. Location - City	or Town, Stata
Important: If is any injury or once.		21. Signeture of Funerei Service Lice		0	22. Name end Addra	ss of Facility Jo	hn C. Mi	ller Inc	•
sician edical miner		23e. Pent1. Enter the disaesa, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in daath)			not antar the mode of dyir nay Custom consequence of): here				Approximate Intervei Between Onset and Deet
19sit	Iner			Dua to (or as e	consequence of):	Difer	2		3 Yrs
end-trar	I Examiner	Sequantially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or Injury	0.	Due to (or as e					
ettending physician for use es the bunei	/Medical	that Initieted events resulting in deeth) Last	d	Due to (or as a c	onsequance of):				
ed by the deteched	y Physician/M	Pert II. Other algnificent conditions of	contributing to death be	ut not resulting in	the underlying cause giv	en in Pert i.			te to the cause of de Probably 40 Unk
hes been signing 2 should be	Completed by						24a. Wes en e performe	autopsy 24b	Wera autopsy findin evallabla prior to completion of ceuse of daath?
age ag							1□ Yas	200	1□Yes 2□X
	To Be	25. Was cese referred to medical axaminer? 1 Yes 2 No	Hospitel:	nt 2□ER/Out	tpatient 3 DOA Oth	26. Piace of Deeth		e 6 □Other (Sp	ecify)
	Certification: 1	27. Manner of Daeth Staturei 5 Pending investigetio	28e. Data of inju (Month, De)	y 28b. T	ime of 28c. injury Wor	vet / 2	8d. Dascribe how		,
	Ific	3 Sulcide 6 Could not be datarmined		ury - At home, fai c. (Specify)	m, streat, factory, office	2	8f. Location (Strae City or Town, S	et end Number or i State)	Rural Routa Number,
Virector: After thi in by the funeral	Cert								
To the Funeral Director: After this completely filled in by the funeral d	edical Cert	29a. Certifier (Check only one) 1 Cartifying Ph 2 Medical Exar	ysician: To the best oniner: On the basis of and mennar sta	examinetion end	daeth occurred et tha tin Vor Investigetion, in my o	ne, dete end place, er plnion, deeth occurre	nd due to the ceus d at the tima, deta	se(s) end menner a end place, end de	as steted. ua to the cause(s)

State Registrar

AUG 2 3 2000





Ple

ANA MCARTHUR	Please Type or Print Ir	Black indelible ink. Assure All	Copies Are Legibi	е.
-4722-510	State of Maryl	and / Department of Health and Me	ental Hygiene	26643
amend item 23a,27 per	me G787 9/28/00 yf	Certificate of Death	Reg. No.	

	1. Decedent's Nama (First, Middla, Last)
Physician /Medical	DIANNA R. MCARTHU
Examiner	4a Facility Name (If not Institution, giva s

Funeral Director

"natural", or flame 23s or 28s-f shor

permit. Pages 1 and 2 should be filled within 72 hours after of beginnant of Health and Martal Hygiena. Insportant: If item 27 is married other than "natural", or item any injury or other traumatic event, the Medical Examines, once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The lew requires that the deeth certificate be associted within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Nama	(First, Middle	a, Last)							2. Date of De			3. Tima	of Death	
n	DIANNA R. MCARTHUR									AUGUS'	Dey Г 19.			7 PM	
al	4a Facility Name (If not Institution, give street and number)							4b. City, Town, or Location of Deeth 4c. County of Deat					PU		
er	CTNIAT	SINAI HOSPITAL							TMOE	DE CITY	N	I/A			
-	5. Social Sacurity Nu		6. Sex	7. Age (In yrs.	. lest birthday	y) If Under		If Under	24 Hrs.	8. Dete of Bir	th	9. Birth	place (Stete	or Foreign	
	220-64-9		1□M 2√F		43 Yrs.	Months	Deys	Hours	Min.	7-10-	y, Year)	Cou	MD.		
	Usual Residence of E							1		, 10	1,55,	1	110 •		
		10b. County		10c. C	ity, Town or I	Location							10d. Inside	City Limits	
5	MD.	MD. N/A B				ALTIMORE							1 Q.Y	s 2 No	
	10e. Street and Num					1	Code				10g. Citizen of What Country?				
		2510 EDGECOMB CIRCLE APT G				101. Zip Code 21215							USA		
		FCOLD							ining (Co	anait. Van au Ni		14. Rece - American Indian,			
5	11. Mental Status		Armed F		If Yas, spe	cify Cut	Hispanic Origin? (Specify Yas or I oan, Mexican, Puarto Rican, etc.)								
Be Completed by F	1 Never Merrie	_ X	If Yes, C	2 No		1 ☐ Yes	2 XNo	o Specify:			Specify: DT		CIZ		
	3 ☐ Widowed 4	Divorced	Yaar or	Dates:							BLACK				
		Decedent by only highes	t's Education of grade completed	1)	(Giv	Decedant's Usuel Occupation (Give kind of work done during most of work				king	16b. Kind of	(ind of Business/Industry			
ŀ	Elementery/Secon	dary (0-12)		(1-4or 5+)		lifa. DO NOT use retired)					TATRICA				
Š	-12-		-0)_	LA	ABORER		1				TRIAL			
3	17. Fathar's Neme (F									ne (First, Middle		em <i>e)</i>			
	CARLIE F	KEESE .	JR.					T	AMOE	SINA PO	RTER				
	19e. Informent's Ner	me/Relations	hip (Type, Print)		19b. Mei	iling Address	s (Stree	and Numb	er or Ru	ral Routa Numb	er, City or Tow	m, Stete, Zi	ip Code)		
	THOMASIN	NA MORI	RIS (MOTHE	ER)	3500	COTT	AGE	AVE.	BAL'	TIMORE.	MARYLA	ND 21	215		
	20a. Method of Dispo				Plece of Disposery, cr	position (Ner	me of			Dete	20c. Location	n - City or T	own, State		
	1 🖾 Burlei 2 🗆		3 Removel from	n Stete	UTUS N				8.	-25-200	O BALTI	MORE.	MARY	LAND	
	21. Signeture of Fun			1		22. Neme er	nd Addr	ess of Facili	**						
		the	() A	fiBre					rn.	ILLIPS					
_	jou	au	0.0.							T. BALT		MARYL	AND 2	1217	
	23a. Pert 1/ Enter the shook, or heert	e disaesa, or failure. List	complications that only one cause on	ceused the dee each line.	oth. Do not e	nter the mod	de of dy	ing, such es	cardiec	or respiretory	orrest,		Approxim Intervel E	etween	
												-	Onset en	o Deeth	
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	resulting in death)		G	Due to (or as a cons	equence of):	:				1				
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	Sequentially list condificant, leading to immodule. Enter Underline	medieta lying										1			
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	resulting In deeth) La	ast		550101	0. 00 0 001101	oqua									
			d									- 1			
Completed by Physician/Medical									iven in Part I. 23b. Did tobacco use contribute to			to the cour	a of dooth 2		
	Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse							Iven in Part							
										10	Yss 2 No	3 Pro	obably 4	Unknown	
										045 1415		24b V	Vere sutops	ny findinge	
-										perf	s an autopsy ormed?	8	vailable price	or to	
				- P- 19-1									death?	7 00000	
E COLL										De	Yes 2□No		Yes 2	□ No	
	25. Was case referred to medical 26. Piece of Deeth (Check bnly one)														
	examiner?		Hospitel:	Innation 25	☐ ER/Outpeti	ent Min	04 0	ther		ome 5 Res		Wher /Spec	rifu)		
	27. Menner of Death								uranig M		how injury occ				
	1 Natural	1 ☑Naturel 5 ☐ Pending				Injury W		vork? ☐ Yes 2 ☐ No							
	2 ☐ Accident 3 ☐ Suicide	2 Accident								28f. Location (Street end Number or Rural Routa Number,					
								City or Town, Stete)				S. FIODIA /V			

1	(Chack only	1∐ Certifyin	g Physician: To the Examiner: On the	ne best of my kn- basis of examin-	owiedge, dea	eth occurred Investigation	et the t	ime, date el opinion, de	nd plece ath occu	, and due to the rred et the time	cause(s) and date end pled	manner as e, and due	stated. to the ceus	e(s)	
-	one) X	1	and ma	nnar steted.											
	29b. Signature and s	itle of certified	. 1	1		29		se number			29d. Date sig				
		- /	1771				(X	ME.			AU(+	01 70	. 200	1	

State Registrar

31. Dete filed (Month, Day, Year)

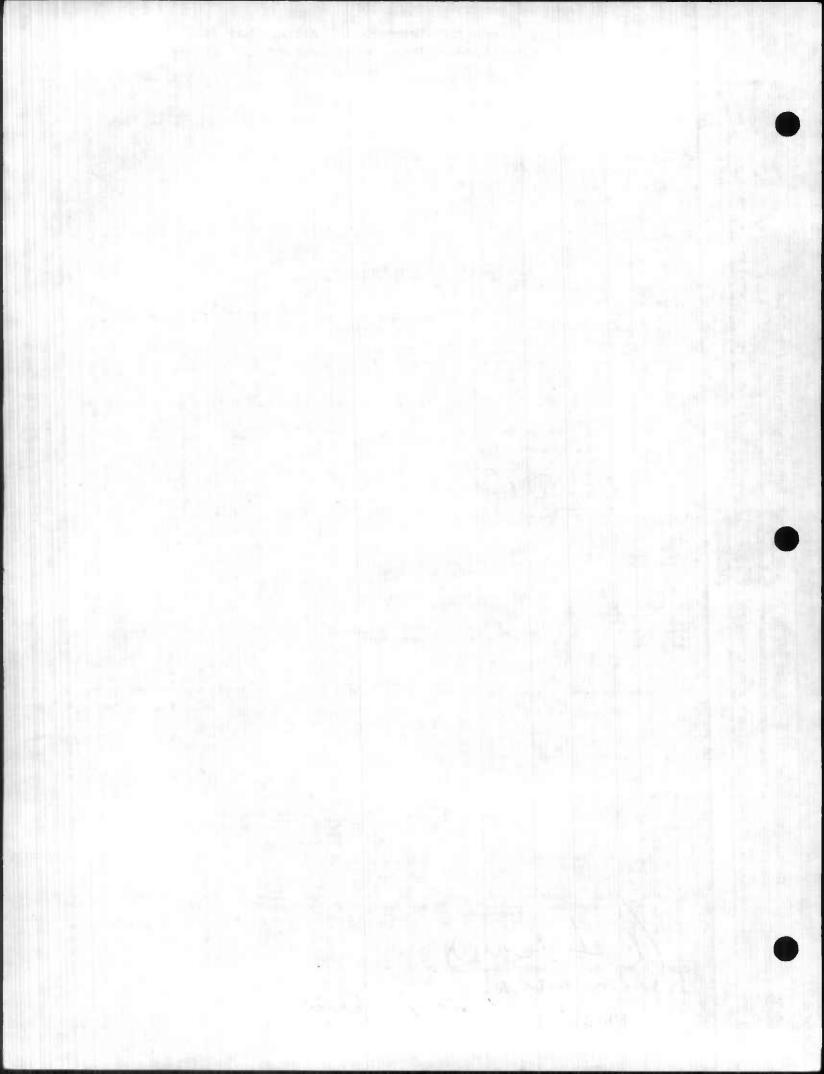
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DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

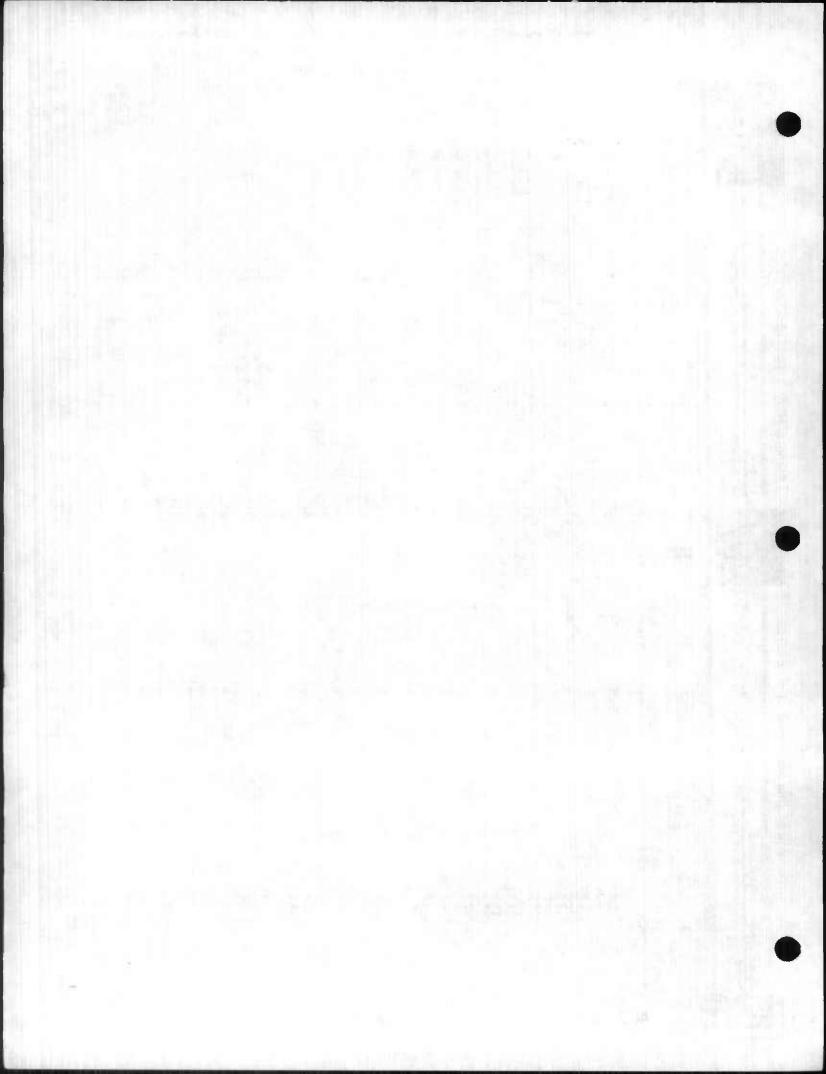
death Jimm 23a) (Type, Print)

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 2664 is

	Certif	ficate of Death	Reg. No.	0 20077							
Section 1	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death							
Physician /Medical	Esther Nebel		August 19	2000 6:10 P.M.							
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	cation of Death 4c. Count	y of Death							
	Genesis Eldercare Caton Manor	Balti		N/A							
Funeral Director	216 09 4516 1 M 2X F 85 Yrs. M	Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 10, 1915 Birthplace (State Country) Maryland									
PS &	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City Limits							
vith the Maryle t or 28a-f sho be notified Director	Maryland N/A Baltimore		Yes 2□No								
th with the Marylar 23a or 28a-f ehow test be notified at	3330 Wilkens Avenue	101. Zip Code 21229	U.S	10g. Citizen of What Country? U•S•							
5-0020 72 hours after death with the Manyland natural; or Hama 23a or 28a-f show sical Examinar must be notified at seed by Funeral Director	Armed Forces? If Ye 1 ⊠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Decedent of Hispenic Origin? (Spess, specify Cuban, Mexican, Puerto Yes 2X No Specify:	Rican, etc.) Bla	o- 14. Race - American Indien, Black, White, etc. Specify: White							
T = 1 3	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	's Usual Occupation d of work done during most of worki NOT use retired)	ng 16b. Kind of E	16b. Kind of Business/Industry							
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Saltim smit. Ps spartment by lejury ass.	L	amo and Address of Escility	Gonce Funeral	Home P.A.							
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Physician /Medical Examiner Paraminer Examiner	Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCUETOTIC CARDIOVASCOUM 5 YEAR Due to (or es a consequenca of): DISTRADIO b.										
6876(trifficate be ng physicia es the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequence of):										
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P.O. hat the deby the Jetache	Catch. Other argumeant conditions continuing to death but not resulting in the under	nying cause given in rait i.	1 Yss 2 No 3 Probably 4 Onknown								
ecords, aw requires as been sign 2 should be pleted by			24a. Wes an autopsy performed?	24b. Wera autopsy findings available prior to completion of cause of death?							
II Relay			1□ Yes 2₽No	1 ☐ Yes 2 ☐ No							
Vital Note: 1 certifical rector, p	25. Was case referred to medical	26. Piece of Deeti	(Check only one)								
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20 _	27. Menner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Injury	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how injury occurred								
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Division To the Hospital or Attending within 24 hours after Geath. To the Funeral Director: Afte completely filled in by the fun Medical Certification											
To the comp	29b. Signeture and title of certifier	29c. License number	29d. Date sign	29d. Date signed (Month, Day, Year)							
	> College Mp	D21776	AUGUS	AUGUST 21 2000							
8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SO (YA MUNDRA W 30-0) S-HANDUCA ST BAZTIMORG										
State	31. Date filled (Month, Day, Year) AUG 2 3 2000 32. Registrar's Signature	1 4									

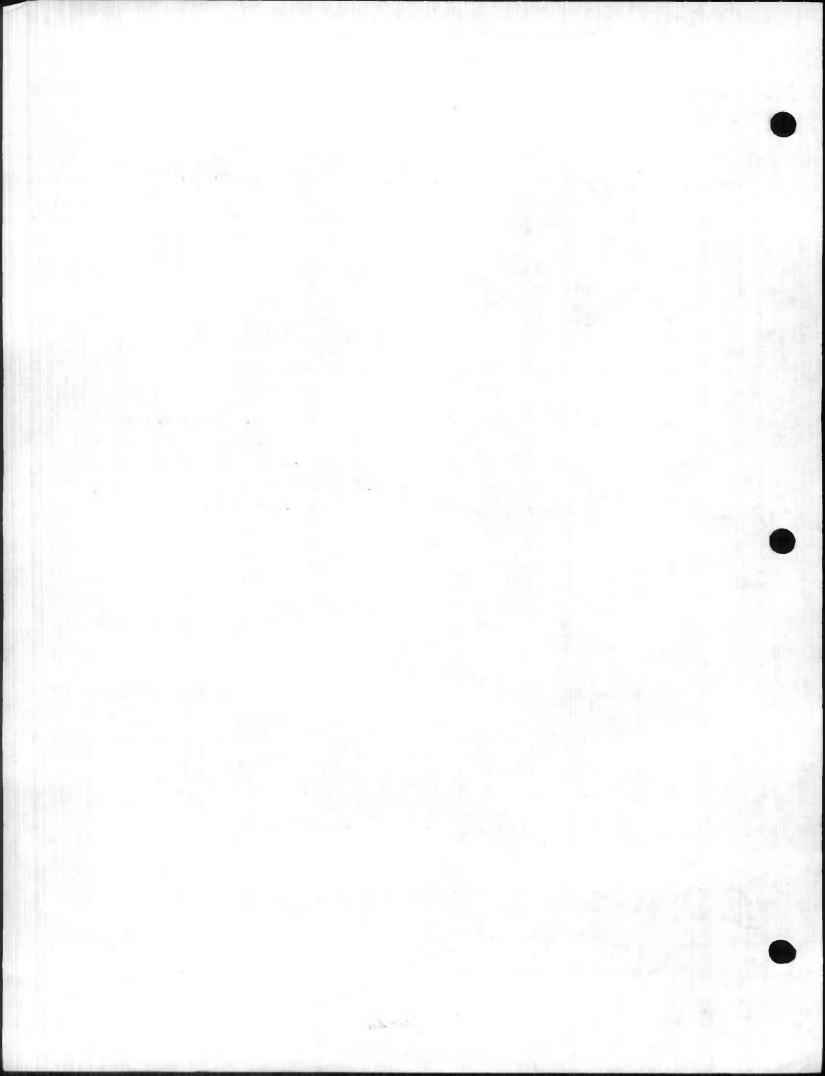


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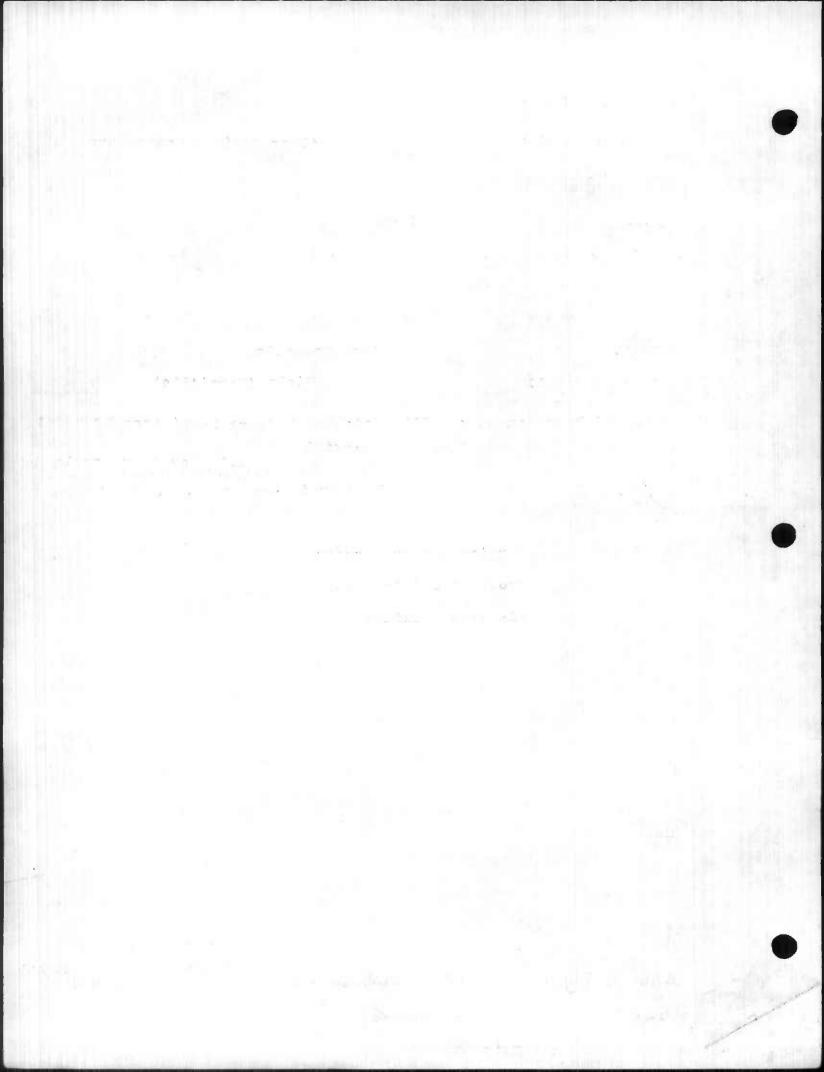
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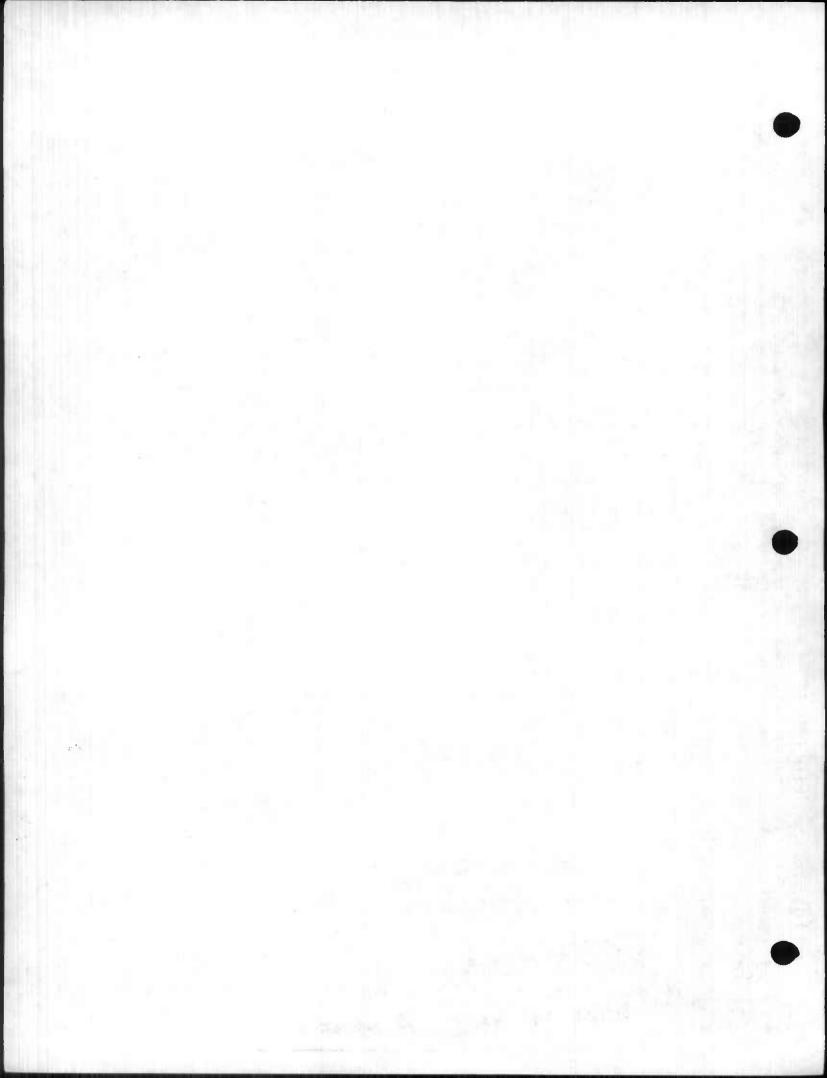
State of Maryland / Department of Health and Mental Hygiene O. O.

			Otate of Ivia	il ylalla / i	Certificate of			Reg. No.	200	40
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	edical	Fannie Bell Pin	`				August	13' 20(05 P.M.
6.11	miner	4a Facility Name (If not institution, gi	va street and number)			4b. City, Town, or L	ocation of Death	4c. County of	Death	
		Holy Cross Hosp	îtal			Silver S	pring	Montg	omery	
Fune	ral			(In yrs. last bii	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da		9. Birthplaca (St Country)	ata or Foreign
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S .		Usual Residence of Decedent 10a. State 10b, County		10c. City, Tow	n or Location				10d. Insid	de City Limits
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G 82	829	11. Marital Status	12. Was Decedent E	ver in U.S.			pecify Yes or No		- American India	an,
Maryland 21215-0020 d 2 should be filed within 72 hours after of th and Merall Hyglere. 7 is marked other than "natural", or then traumatic event, the Medical Exercises.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yas 2 N If Yes, Give Yaar or Dates:		13. Was Decedent of If Yes, specify Cut		Rican, atc.)	Specify:	, White, etc. Black	
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lid be	ToB	Jesse Cornw	ell			Viola	(Unvai	lab1è)		
Short Short	-	19a. Informant's Name/Relationship	(Type, Print)	196	. Maiting Address (Stree	t and Number or Rui	ral Route Numbe	er, City or Town, S	itate, Zip Code)	
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Physician: The law this certificate has rail director, page 2	e	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Dea	th (Check only o	ne)		
Physical distribution of the state of the st	To	1 Yes 2 No 27. Manner of Death	1 Linpatier	27.27	Itpatient 3LI DOA	4 LI Nursing H		dence 6 Otha		
OVISION OF VICE INCOCAS, I or Attending Physician: The law requires the free death. Director: After this certificate has been signed in by the funeral director, page 2 should be et	lo	12Oslatural 5 ☐ Pending	28a. Date of tnjun (Month, Day		Time of 28c. tnju		280. Describe i	now injury occurre	d	
Attending or death.	Cat	2 Accident investigation 3 Suicide 6 Could not t	va	4.1		Yes 2 No	Opt Leasting (Otropt and Misson ha	a a a Domit Davida	Abumbas
or Attended of the death of the	Certification:	4 Homicide determined		ry - At noma, te . (Specify)	irm, street, factory, office		City or Tox	Street and Numbe vn, State)	r or murai moute	ryum <i>ber</i> ,
urs urs	Ü	COn Contillar at the control of						0.12		
Hoe 24 ho Fundal	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	miner: On the basis of	axamination an	 death occurred at the t d/or invastigation, in my 	me, date end place, opinion, deeth occur	red at the time,	causa(s) and mar date and place, a	ner es stated. nd due to the ca	use(s)
To the Hospital or Attending Physician: Within 24 hours after death. To the Furneral Director: After this certific completely filled in by the funeral director.	9 W	29b. Signatura and Atle of certifier	and mannar stat	ad.	29c. Lican	sa number		29d. Dafa signed	(Month Day Va	uar)
F.≱₽8		///	0	11					-1111	
		1 Jung	Ken	1	cy D52	701		August 1	3,2000	
10		30. Name and tress of person who			(Type, Print)	. 2.	Silva	R		20902
3		Alan R Sega		1299	Lanberte	IN Drive	Jpm	ng Mo	mand	
	State	AUG 2 3 2000	32. Registra	2 Signature	1001			4		
neg	istrar	תטע איט בטעט	1	~ 1	1160 160					



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		nate of Maryland	Certificate		Re	ig. No.	20091
Physician	Decedent's Neme (First, Middle, Last)	Olamana Ma	Da		2. Date of Deeth Month	Day Yes	
/Medical	4a Facility Neme (If not institution, give street	Clarence Wa	yne Parsons	4b. City, Town, or L	AUGUST ocation of Death	18, 2000 4c. County of De	5:38 A. M.
Examiner	St. Agnes Hospit			Baltimo		N/A	
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. let 53	Yrs. If Under 1 \ Months D		8. Date of Birth (Month, Dey, Oct. 13	Year) 9. E	Birthplece (Stete or Foreign Country) Maryland
Z 2	Usual Residence of Decedent 10a. Stete 10b. County	10c. City,	Town or Location				10d. Inside City Limits
28a-f sho notified a	Maryland Baltimore	Ba1	timore				1 ☐ Yes 2 No
23e or 28e-f shout be notified at all Director	10e. Street and Number 2836 Louisiana Aver	nue	10f. Zip Co 2.	de L227	10	Og. Citizen of What	Country?
ar, or items 23 Examiner must by Funeral	1 Never Merried 2 Married	Was Decedent Ever in U,S. Armed Forces? 1.20 Yes 2 □ No If Yes, Give Yeer or Detes:	13. Was Deceden If Yes, specify 1 ☐ Yes 2 ₺	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Bleck, W Specify:	merican Indian, hite, etc. White
other the Medical event, the Medical Be Completed	15. Decedent's Education (Specify only highest grade co	on impleted)	16e. Decedent's Usual C (Give kind of work of life. DO NOT use r	occupation lone during most of work	king	16b. Kind of Busines	ss/Industry
omo	Elementery/Secondery (0-12) 12th	College (1-4or 5+)	Maintenance			Chemical	Company
ent, le	17. Father's Name (First, Middle, Last)			18. Mother's Nem	e (First, Middle, M	faiden Surneme)	
marked other matic event, To Be C	Clar	rence E. Pars	sons	Et	thel McGu	ire	
27 is marked or r traumatic ev	19e. tnforment's Neme/Reletionship (Type, Sharon Parsons /	Print) Wife		treet and Number or Rui Lana Avenue			yland 21227
10	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Remo	20b. Ple	ce of Disposition (Neme netery, cremetory or othe ar Hill Ceme	of r plece)		20c. Location - City	-
mportant: any injury ance	4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee	ceu	22. Name end A	ddress of Fecility	Gonce Fu	neral Ho	me P.A.
	23e. Pert1. Enter the diseese, or complication shock, or heart failure. List only one complex to the complex of	Megar	4.4	chie Highwa	-		ZIZZ5 Approximete
physician and street and street Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c		e cotic Co is a consequence of):	Vd10V636~	le Dis	9239	years
nding physicia usa as the bur in/Medical	Cause (Disease or Injury that initiated events resulting in deeth) Lest	Due to (or e	s e consequence of):				
the atte	Pert II. Other significant conditions contribu	uting to death but not result	ing in the underlying caus	se given in Part I.	23b. Dld to	bacco use contrib	ute to the cause of death?
igned by the be detached by Physical by Ph					1 🗆 Ye	s 2□No 3□	Probably Unknown
should should					24e. Wes er perform		b. Were eutopsy findings available prior to completion of cause ot death?
page 2					1 ☐ Ye	s 22 No	1 ☐ Yes 2 ☐ No
certificate rector, par	25. Wes case referred to medicat examiner?				th (Check only on	e)	
S P P	1 Yes 2 No Hosp	1 Inpatient 2575	R/Outpatient 3 DOA 8b. Time of 28c.			nce 6 Other (S	Specify)
leath. tor: After the fune cation	2 Accident Investigation	(Month, Dey Year)	М	Injury at Work? 1 Yes 2 No			r Rurel Route Number,
ours after of eral Direct filled in by	4 Homicide determined	28e. Plece of Injury - At hom building, etc. (Specify)	e, lerni, street, lectory, o	ilice	City or Town		110011000
within 24 hours a To the Funeral C completely filled Medical Ce		an: To the best of my knowl On the basis of examinetic and menner steted.					
To the	29b. Signature end title of certifier		29c. L	icense number	29	9d. Dete signed (M	onth, Day, Year)
)	30. Name end address of person who compl	iting phy	SICICO X	>51853	F	tugust	18, 2000 ore 21229
1	Michael Silver	man, MD	900	Caton A	venve	Balton	ore 21229
State Registrar	31. Date filed (Month, Dey, Year) AUG 2 3 2000	32. Registrer's Signetu	6 1	4			

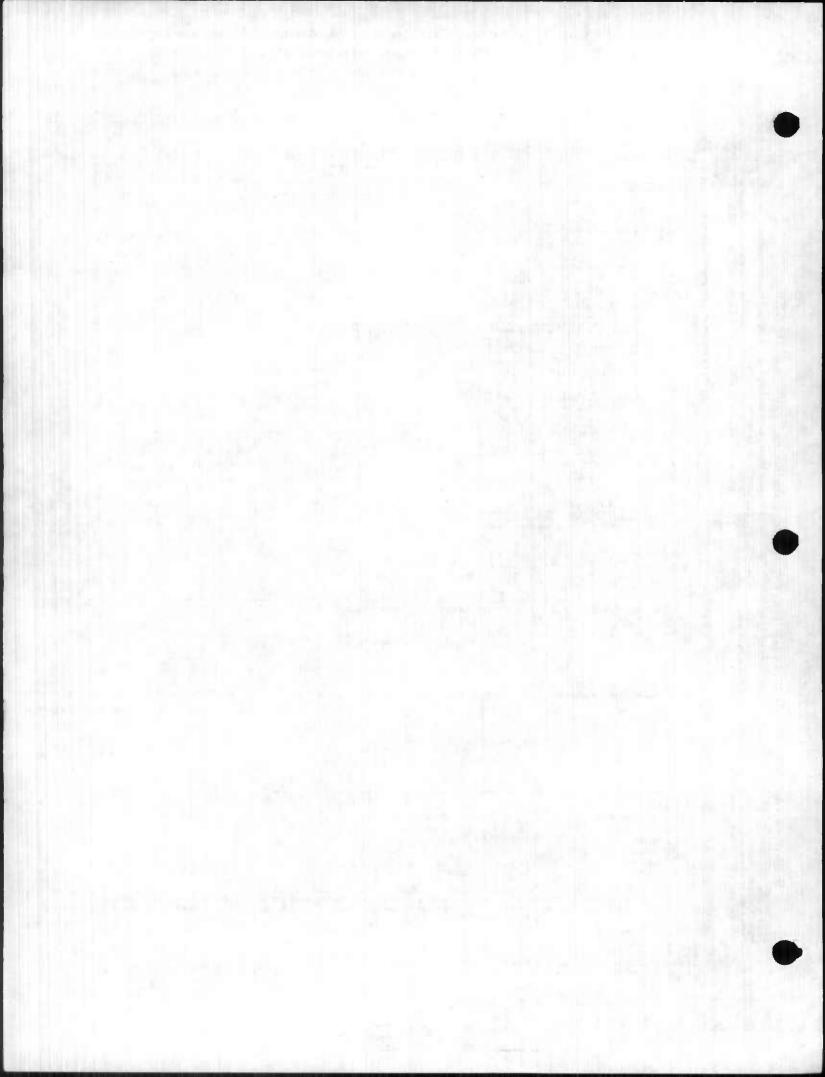


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State of Maryland / Department of Health and Mental Hygiene ()

26648

					Certifica	ile ui Deal	111	Reg.	No.		
	_	1. Decedent's Neme (First, Middle, Last	")				2.	Data of Death Month	Day	3. Time of De	ath
Physicia	_	Lucille	N.	Pr	OW		Δ1	qust_1	9 200		
/Medic Examin	_	4a Facility Nama (If not institution, giva				4b. City,	Town, or Locati		4c. County		
	-	Johns Hopkins 1	Ravview	Medica	1 Cent	or Ral	ltimore		N/a		
Funeral		5. Social Security Number 6. Sa		e (In yrs. last bi	rthday) If Und	ler 1 Yeer If Und	Ltimore dar 24 Hrs. 8.	Data of Birth (Month, Day, Ye		9. Birthplace (Stata or Fo	oraign
Director			3M 2DF 8	7	Yrs. Month	s Days Hour		oril 25		Country)	
9		Usual Rasidance of Decedant									
ylan May	20	10a. Stata 10b. County		10c. City, Tow	m or Location					10d. fnsida City L	-
2 7	to	Md. Baltimon	re	Dii	ndalk					t □ Yes 2	No
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Directo	10e. Street and Number				Zip Coda		10g.	Citizan of W	hat Country?	
and		2412 Meadow I	Road			21222		4 - 10 -	U.S.	Δ	
doan Cms 2	Funeral	11. Marital Status	12. Was Decedent	Evar in U.S.	13. Was Dec	edant of Hispanic pecify Cuben, Mexi	Origin? (Specifi	Yes or No-	14. Raca	- American Indien,	
O de la	2	1 Nevar Married 2 Married	Armed Forcas? 1 ☐ Yas 2 ☑	No		. 4		an, atc.)		k, White, atc.	
020	by	3 ☐ Widowed 4 ☼ Divorced	If Yes, Give Yaar or Datas:		1 LJ Yas	2) No Spec	eify:		Specify:	White	
21215-002Cd within 72 hours at pene. or then "netural", or the Medical Exem	Completed	15. Decedent's Edu	ication	16a	. Decedent's U	suel Occupation	nest of working	168	. Kind of Bu	sinass/Industry	
12 mm	oldi	(Specify only highest grad Elementery/Secondery (0-12)	College (1-4or	5+)	lifa. DO NOT	usa retired)	nost or working				
	Com	9th			HOME	MAKER			OWN	HOME	
D all the	Be	17. Father's Name (First, Middle, Last)				18. Mc	othar's Nama (F	irst, Middla, Mai	den Sumeme	B)	
A Manual Annual	0	Conrad Wagner	Brock	man		Ma	rie	. Pet	ers		
Maryland 12 should be file to and Mental Hy 7 is marked other treumatic event		19a. Informent's Name/Raiationship (T			o. Meiling Addre	ess (Street and Nu	mber or Rural R	outa Number, C	ity or Town,	Stata, Zip Code)	
N Dang	1	Mary Lu Moskowit	z/Daugh	ter 2	412 Me	adow Ro	oad. Ba	alto.	Md.	21	
off Heart		20a. Mathod of Disposition		20b. Placa o	of Disposition (A	/ama of		Data 200	Location - 0	City or Town, State	
L Pages 1. Iment of He Sant II floor sant of He		1 Buriel 2 Crametion 3 1 4 Donation 5 Other (Specify,		METR		MATIN		000 C	4 Tons	ville MI	b .
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W FOLKS		Mhttm. 1		20011		nelly !	meral	Hone Rs.	RAIN	A MA > 1	> 2
		23a. Parl1. Entar the disease, or comp shock, or heert failure. List only of	lications that caused	Wheldeath Dd	not enter the m	Sollers ode of dving, such	Point as cardiac or re	spiratory arrest	DAC	Approximata	62
Discontinuo.		shock, or heert failure. List only o	na causa on each I	na.	1					Interval Between Onsat and Daa	an ath
Physician /Medical		Immediata Causa (Final	X	1.71	1	A W	1			21	
Examiner		disaasa or condition resulting in death)	a	55514	Hu.	et e	1			249	
	ě		11	Dua to (or as a	consaquence	1):	-			1-1-	
De l'isit	Examiner		b. 10/0	141	erra.	the son	Luc			5 Ty	
60, be executed ician end burial-fransit	Exa	Sequantially list conditions, if any, taeding to immediate causa. Enter Undarlying Cause (Disease or injury that initieted evants		Dua to (dr as a	consequence o	n):					
cate be exphysician		Cause (Disease or injury that initiated evants	с.	D		n.			_		
octificate be e	8	resulting in death) Last		Dua to (or as e	consequence o	1).					
Central Centra	2		d								
Geath death	Completed by Physicia	Death Other deathers and discount				and the state of the state of	- 41	22h Didtaha		tributa to the cause of d	death?
P.O. By the death detached for	ysi	Part ff. Other significant conditions co	ntributing to death b	ut not rasulting i	in tha undariyin	g causa given in Pa	Brt I.			/	
that the ded by detac	4							1 🗆 Y86	2 No	3 Probably 4 Uni	KNOWN
w requires that been signed to should be det	D							24e. Was en a	utopsy	24b. Wara autopsy find	lings
Deen reduction	ete							performe	d?	available prior to completion of caus	
Sec has the second seco	du									of death?	
al Re								1 🗆 Yas	20 No	1 ☐ Yes 2 ☐ No)
of Vital Re-	Be	25. Wes casa refarred to medicat axeminer?	Hospital:				lace of Death (C	Check only ona)			
Of Physics of this cal dir	2	TES ZETNO	1 Li Inpatie	ent 20 ER/O				5 Rasidend			
On O ding Ph h. After th funeral	O	27. Menner of Death 1 ☑Netural 5 ☐ Pending	28a. Data of Inju (Month, Da		Tima of Injury	28c. tnjury at Work?		I. Describe how	injury occurr	90	
Attending or death.	cat	2 Accident Invastigation 3 Suicide 6 Could not be			M	1 Yas 2		1 10		0 10 11	
Division of Vital Records, or Attending Physician: The law requires the recent their base been signed by the funeral director, page 2 should be of the by the funeral director, page 2 should be or the funeral director.	들	4 Homicida determined	28a. Plece of Inj building, et	ury - At homa, fi c. <i>(Specify)</i>	arm, straat, fect	ory, office	281	City or Town, S	et and Numbe Stafa)	er or Rural Route Number	Γ,
Division To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Certification:										
t hou	cai		sician: To the best							nnar as stated. and dua to tha causa(s)	
the H		one)	and menner st	ated.							
T vit	Σ	29b. Signatura end titla of certifiar	1	/		29c. License numb		290	-	(Month, Dey, Year)	
		,	1	7		D142	21		0	22.20	
1/1		30. Name and address of person who co	ompleted causa of d	aath (Item 23a)	(Type, Print)	1 1					
X		1. A. A	Kowe.	2	-23	F- Blo	0 Br.	167	Eng	, 4225	
Stat	te	31. Date filed (Month, Day, Year)	32. Registr	er's Signature	,					/	
Registra	ar	AUG 2 3 2000	1	i i	1	2					
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JACK AUGUST 20, 2000 POLANSKY 8:20 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (ff not institution, giva street and number) 4c. County of Death Examiner HOSPICE OF BALTIMORE - GILCHRIST CENTER TOWSON If Under 24 Hrs. BALTIMORE Birthplaca (State or Foreign Country) If Undar 1 Yaar 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1√ M 2□ F Hours 216-12-8517 77 FEB. 3, 1923 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4001 OLD COURT ROAD #302 21208 U.S.A. Funeral 12. Was Dacedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status Yes 2 No Yes, Give 1 ☐ Never Married 2 ☑ Married 21215-0020 1 Yes 2√2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STOCK BROKER SECURITIES Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) 8 **OZER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Hostin ELAINE POLANSKY / WIFE 4001 OLD COURT ROAD #302 - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata Pages Burial 2 Cremation 3 Removal from State BETH JACOB CEMETERY 8/22/00 4 ☐ Donation 5 ☐ Other (Specify) FINKSBURG, MD 21. Signature of Euneral Service Licansee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 blent 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Final diseasa or condition resulting in death) Examiner to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Viital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify 1 Yes 2 No Certification: To of 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation Director 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and tale of certif 29d. Date signed (Month, Day, Year) ause of death (Noth 23a) (Type, Print) N. Chales the filled (Month, Day, Year) 32. Registrar's Signatura State 3 2000 Registrar

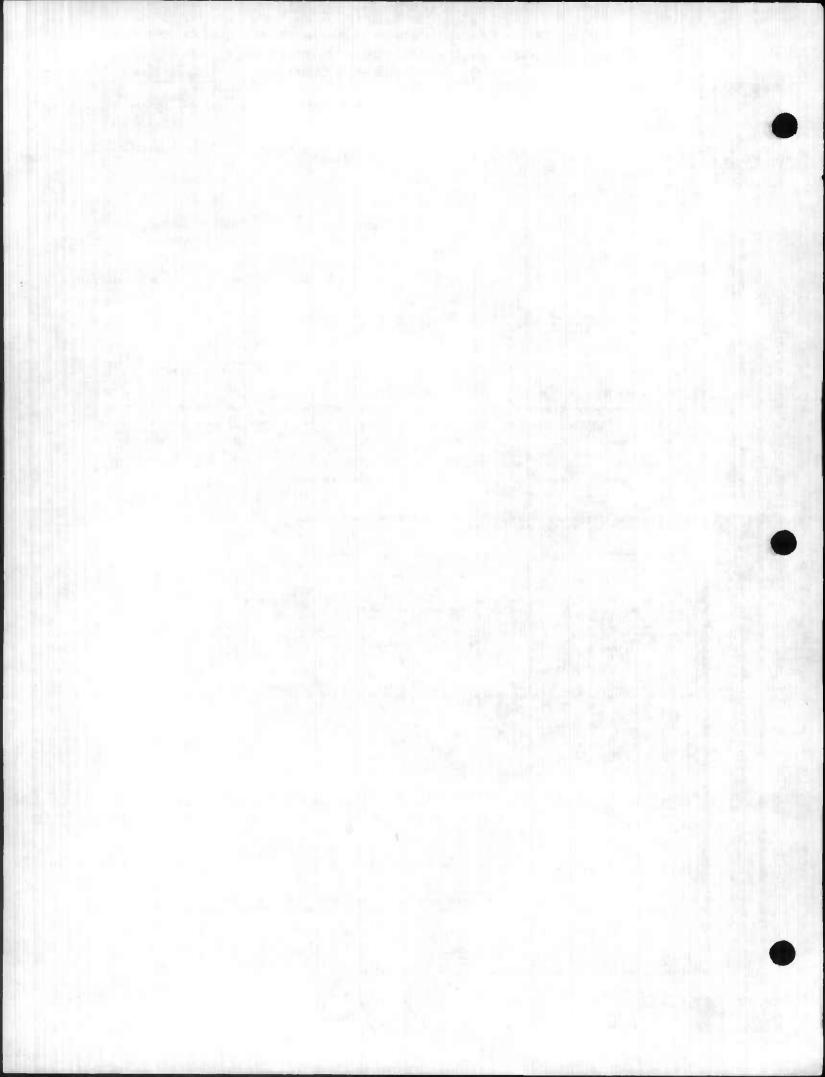
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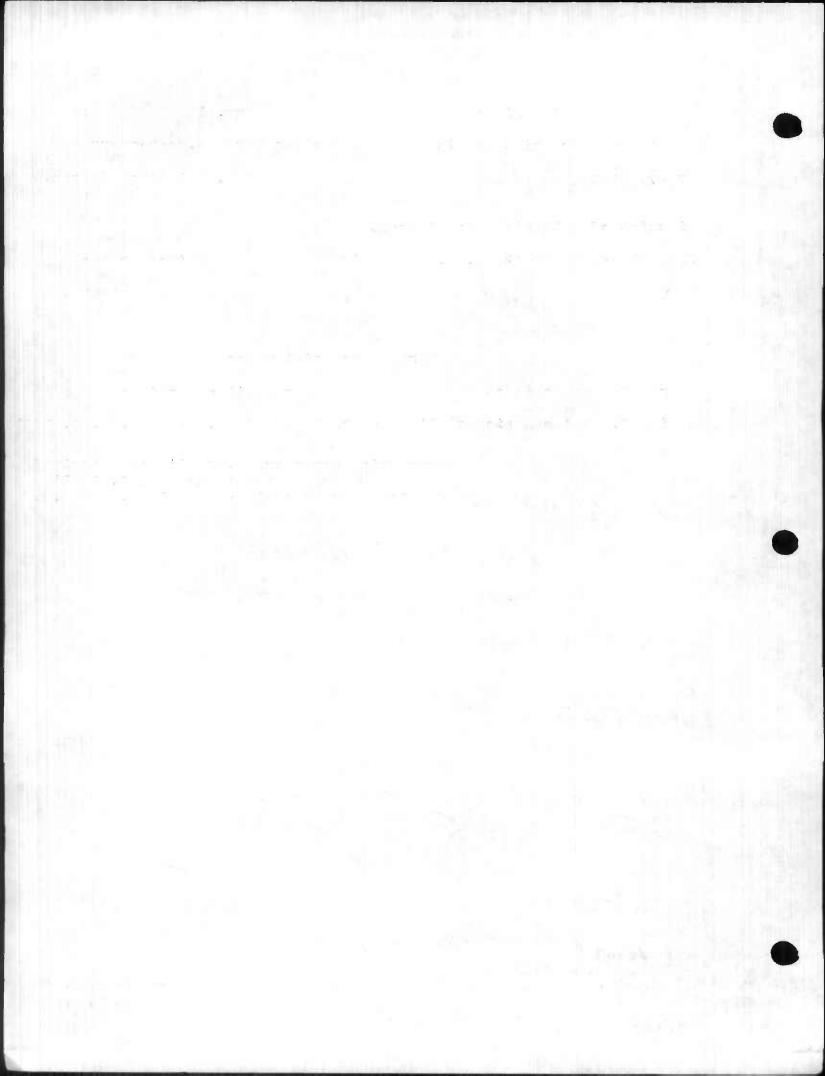


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State of Maryland / Department of Health and Mental Hygiene

	Cer	tificate of Death	Reg. No.	20000
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey	3. Time of Death Year
/Medical	Stephen Rene' Robinson		Aug. 16, 200	
aminer	4a Facility Name (#not institution, give street and number)		Location of Death 4c. County	
	Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Takoma funder 1 Yeer If Under 24 Hrs	Park Md. Montg	
	120 M 2□F Yrs.	Months Days Hours Min	. (Month, Dey, Year)	Birthplace (State or Foreign Country)
	578-74-8763 44 Usual Residence of Decedent		Feb. 27, 1956W	ashington, DC
	10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
to	District of Columbia Washingto	n		1 X Yes 2 □ No
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of W	/hat Country?
	3109 Chestnut Street, N. E.	20018	United	States
מופומו	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (5	Specify Yes or No- 14. Race	- American Indian,
	1 M Never Married 2 ☐ Married 1 ☐ Yes 2 M No	Yes, specify Cuben, Mexican, Puer Ves 2 No Specify:		k, White, etc. Black
	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	THE 200 NO Specify:	Specify:	
ted	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give.	ent's Usual Occupation	16b. Kind of Bu	siness/Industry
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)		
j		House Mainten		
Re	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sumem	0)
9	Andrew Joshua Robinson		Wilson-Robin	
		g Address (Street end Number or R		
		Chestnut Stre		And the second s
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	netory or other plece)	Date 20c. Location -	City or Town, State
	4□Donation 5□Other (Specify) Resurred	ction Cemetery		
		. Name and Address of Facility W		
	Jahn W Latury 30 CC 0348 La	tney's Funera	1 Home 3831 G	a. Ave, N.W.
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cerdia	c or respiratory arrest,	Approximate Interval Between
				Onset and Deeth
	Immediate Cause (Final disease or condition	GYND ROLL,	5	
	resulting In death) Due to (or as a consequence)	uence of):		
Examiner	- ACQUERED IMI	SYNDROULD UNEDEFICIA	evcy dynore	MA
cam	Sequentially list conditions, Due to (or as a consequence)	uence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
Medical	that initiated events resulting in death) Last Due to (or es e consequence of the consequ	uence of):		
Me				
	0.			
Physician	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying ceuse given in Part I.	23b. Did tobacco use cor	ntribute to the cause of death?
Phy	Funk Africa		1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
by	07,70			A. W
ted			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
Completed				of death?
Co			1 ☐ Yes 2 ☐ No	t ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?		eath (Check only one)	
0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		Home 5 ☐ Residenca 8 ☐ Other	er (Specify)
:uo	27. Manner of Death 1. □ Natural 5 □ Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurr	ed
ati	2 Accident investigation	M 1 Yes 2 No		
Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Suicide 4 Homicide 4 Suicide 4 Romicide 4 Romicide 5 Could not be determined building, etc. (Specify)	eet, factory, office	28f. Location (Street and Numb City or Town, State)	er or Rurel Route Number.
Cer				
edicai	29a. Certifier (Check only (occurred at the time, date and place	e, and due to the cause(s) and ma	nner as stated. and due to the ceuse(s)
	one) and manner stated.			
Σ	200. Signature and little of certifier ATTANDING PHYSICIA	29c. License number	29d. Data signer	(Month, Day, Year)
	AMD THE STOCK	07449	0/10/	00
	30. Name and address of person who completed cause of death (ftern 23a) (Type,	Print)	0000	
	RAYMOND NWADUKUMO 9831 GA	CARN BECT RD	STE 101, KANH	an UD20706
tate	31. Dete filed (Month, Dey, Year) 32. Registrar's Signature	1		
istrar	AUG 2 3 2000 Server & Span	K		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26651 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Physician AUGUST Vermon Ralph Randall 9:55 P.M. 20 2000 /Medical 4e Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL KOSEDALE CENTER If Undar 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Days Hours 1 M 2 F Yrs. Director October 25 1927 Baltimore, Maryland 220 20 4175 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Baltimore Baltimore County 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2 21237 4902 Ridge Road USA Funerai 14. Race - Amaricen Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) or hama 11. Marital Status 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White À 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Registrar Maryland State 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 1 and 2 should be Health and Mental Edna May Reese Roland Emerson Randall 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) # of of Health : If Hern 27 h 4902 Ridge Road Baltimore, Maryland 21237 Dorothy A Randall (Wife) 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith August 24, 2000 Baltimore, Maryland 21. Signatura of Funeral Service Licensee 22. Nama and Addrass of Fecility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaese or condition resulting in deeth) /Medical INTRAVENTRICULAR BLEED Examiner Due to (or es a consequence of) Physician/Medicai Examine Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Hospital or Attending Physician: 25. Was case referred to medicet examiner? 26. Place of Deeth (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 9 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Death 28d. Describe how injury occurred Injury et Work? After 1 Meturel 5 Pending investigation 1 Yes 2 No death. 2 ☐ Accident after death 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Test Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29a, Certifier completely To the

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Baltimore, Maryland 21215-0020

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Division of Vital Records,

ANDALL,

31. Date filed (Month, Day, Year) AUG 2 3 2000 Registrar

29b. Signatura and titla of certifiar

8114 SANDPIPER CIRCLE #20, BALTIMORE, MD 21236 DANIEL SHINNERS, MD 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

29d. Dete signed (Month, Day, Year)

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26652 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **GEORGE** RISMONDO 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPI tal Baltimore Asnes 900 caton AVE Saint If Under 1 Year 5. Social Security Number H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 M 2 □ F Days 79 398-02-8443 DEC. 27, 1920 AUSTRIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes ▼□ No BALTIMORE CATONSVILLE 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 711 ACADEMY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Race - American Indian Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Warried 1 Yes 2∑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BIOCHEMIST HOSPITAL LABORATORY 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) TERESA KIN VJEKOSLAV RISMONDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2891 COUNTRY LANE, ELLICOTT CITY, MD 21042 ALEX STANKOVICH/Son-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GOOD HOPE CEMETERY 8/22/00 MILWAUKEE, WISCONSIN 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 21. Signature of Funeral Service/License 5555 TWIN KNOLLS ROAD, COLUMBIA, MARYLAND 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DYAL Immediate Cause (Final disease or condition resulting in death) ILROSERSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown PHEUMONIA ASPIRATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or its

aitimore, Maryland 21215-0020

the Maryland

physician and s tha burial-fren signed by the has 1º Certification:

of Vital Division ofter death.

PEORGE.

RIS MONDO

To the Hospital or Atta-within 24 hours after dea To the Funeral Director completely filled in by the

Medicai

29e. Certifier (Check only one)

29b. Signature and title of certifier

erfon RESIDENT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALL QUIST- TITEIZSON 34:

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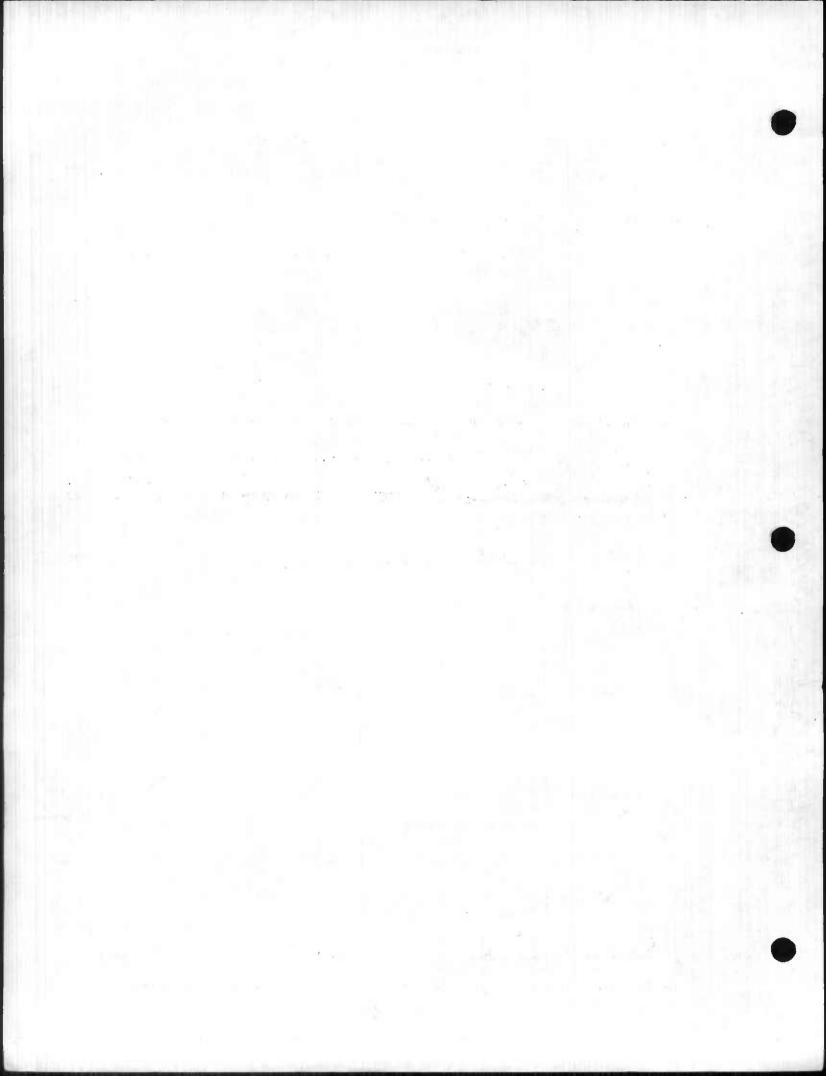
8-18-2000 HORPITAL. 900 CATION AVE BALTIMORE

State Registrar 31. Date filed (Month, Day, Year) r.u 23 2000 32. Registrar's Signature Deperon

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

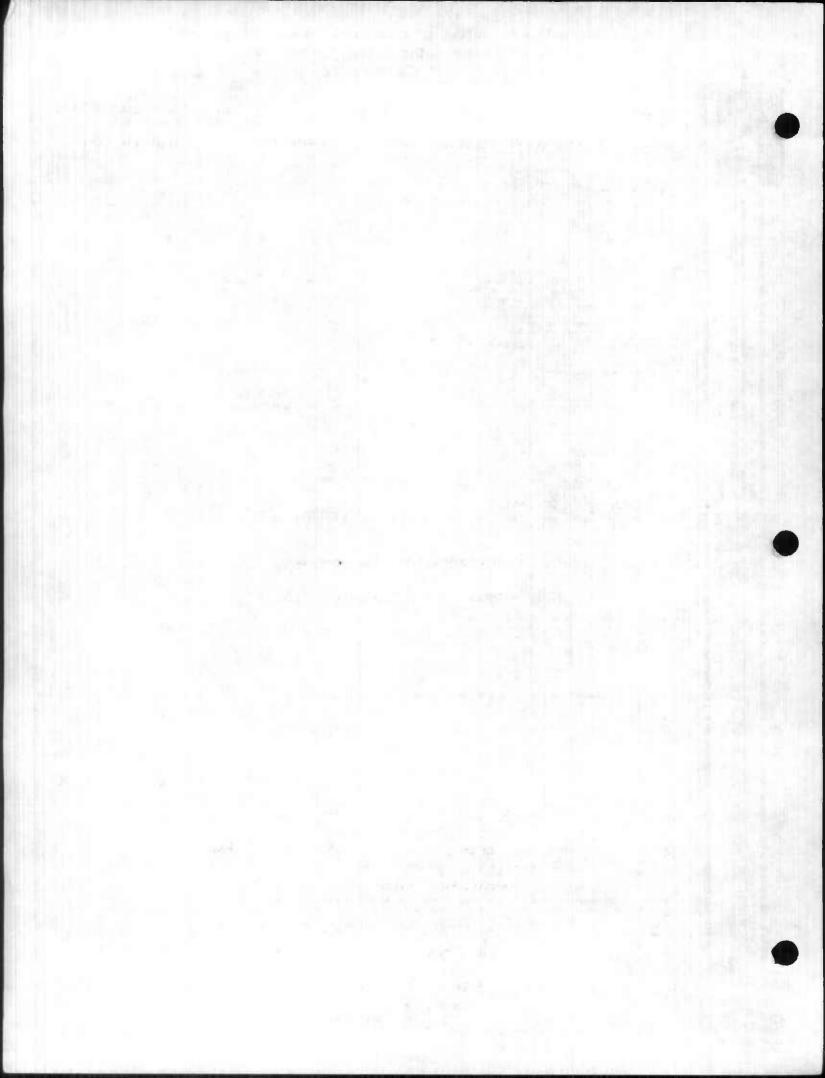
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ral tor	215 22 5861	1 ⊠ M 2□ F	72	Yrs. Months	Days	Hours Min.	8. Date of Bir (Month, Da Jan 8,	1928	Count	land
by Funeral Director	10a. Stata 10b. County		10c. City, Tox	wn or Location					10	d. Inside City Limits
tor	Maryland Baltim	ore	Lanso	downe						1 ☐ Yes 2X No
i Direc	10e. Street and Number 4230 Hollins Fe	erry Road A	nt. 102		ip Code 2122	7		10g. Citizen of V		ry?
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Dec	edent of H	ispanic Origin? (S In, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Rac Blac Specify	e - America ck, White, e	
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Be (17. Father's Name (First, Middle, Las					18. Mother's Nar			-	2-1-2-1
2		Joseph Ren	ehan			R	ita	(not	avaı	lable)
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	20a. Method of Disposition 1 Burial 2 Commation 3 4 Donation 5 Other (Special Commands)		cemete	ew Crematory or	other plac		8/22/00			Maryland
MIKE	21. Signature of Funeral Service Lice	ensee ramua	urhe			ss of Fecility ie Highw		Tuneral imore,		
n	23a. Part 1. Enter the disease, of conshock, or heart failure. List only	mplications that caused by one cause on each li	d the death. Do	not enter the mo	de of dyin	g, such as cardiad	or respiratory a	rrest,	9	Approximata Interval Between Onsat and Death
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y Physician/M	Part II. Other significant conditions	contributing to death b	out not resulting	in the underlying	cause giv	en in Part I.	23b. Did		-	the cause of death?
by	Part II. Other algnificant conditions	contributing to death b	out not resulting	in the underlying	cause giv	en in Part I.	1 🗆		3 Prob	
by	Part II. Other significant conditions	contributing to death b	out not resulting	in the underlying	cause giv	en in Part I.	1 🗆	Yea 20 No an autopsy primed?	3 Prob	ebly 4 Unknown re autopsy findings illable prior to noletion of cause
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	Amended :	Ιtε	em#28b,28f per	MEOG786			ı yıcı ı		ificate of	Death		Reg. No.	UZ	26654
	Physicia	_	1. Decedent's Name (Fi	irst, Middle, L	Last))		2. Data of De Month	Day	Year	3. Time of Death
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	Examine	r	University of				lical	Syste	u	Baltimore	2		more (ity
	Funeral		5. Social Security Numb		Sex 1□MM 2□ F		(In yrs. I	last birthday)	If Under 1 Yea Months Days		8. Date of Bir (Month, De	th	9. Birthpl Count	ace (State or Foreign
	Director		N/A Usual Residence of Dec	cedent			24	Yrs.			Sep 12	, 1975	El S	alvadore
	deeth with the Maryland ms 23a or 28a-f show mat be notified at			b. County			10c. City	, Town or Loca	ition			12/15	10	Od. Inside City Limits 1 ☐ Yes 2 🐼 No
	the M	Director	Maryland 10e. Street and Number	N/A			Bal	timore	10f. Zip Code			10g. Citizen of	What Count	21
	with with		810 Mapleci		w.i				21220					
	deeth	runera	11. Marital Status	est D	12. Was De	cedant Ev	er in U,	S. 13. W	as Decedent of	Hispanic Origin? (S ban, Mexican, Puart	pecify Yas or No	- 14. Re	vador ce - America ack, Whita, e	an Indian,
Maryland 21215-0020	o	2	1 Nevar Married 3 Widowed 4			2 X No	,		Yas 2 No		o moan, etc.)	Speci		spanic
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Man	2 4 4 5		19a. Informant's Name	'Relationship	(Type, Print)			19b. Mailing	Address (Street	et and Number or Ru	ural Route Numb	er, City or Town	n, State, Zip	Code)
	other tr	-	Mauricio Re	-	Father		20h P	810 Ma	plecres	st Drive,	Baltimo	re, MD	2122	
Baltimore,			1 XBurlal 2 Ci	remation 3		n State	0	emetery, crema	itory or other pi		7/12	Cantor	Yolo	gual,
alti-	그는 본론	-	21. Signature of Funara				Ur	22.	Name and Add			El Sal		e
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			23a. Part1. Enter the of shock, or haart la	isease, or co	emplications that	caused to	he daath							Approximate Interval Between
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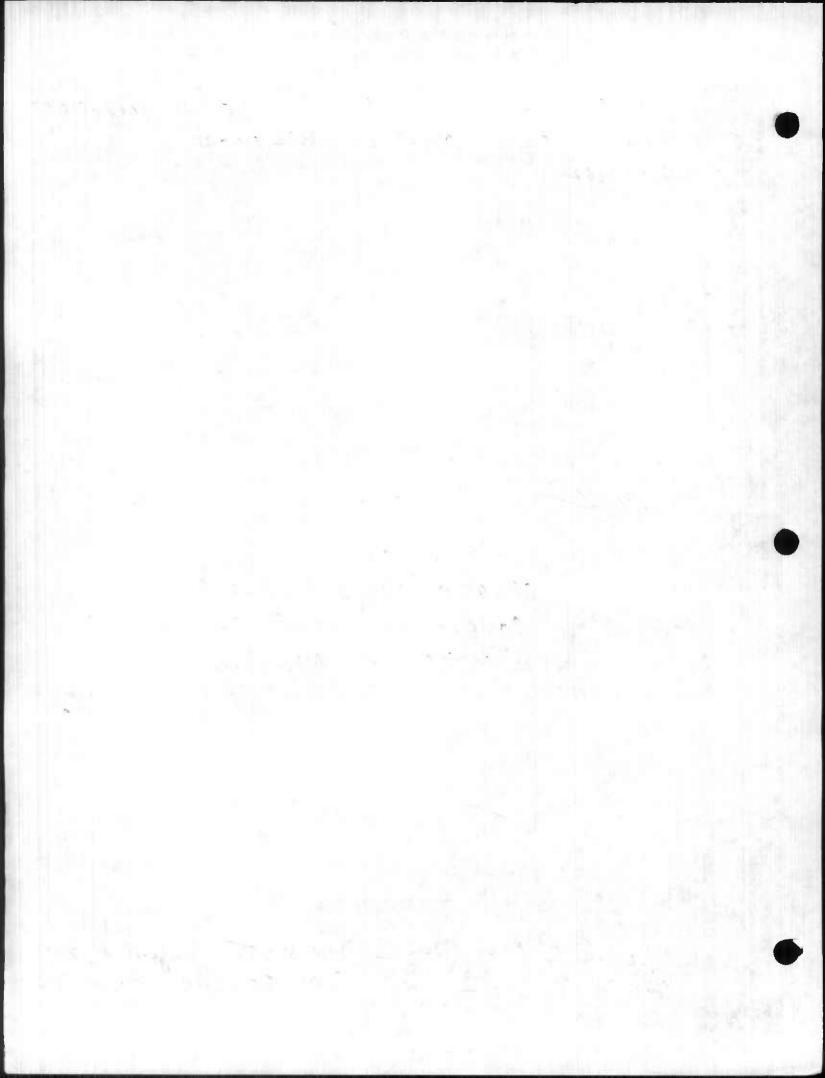
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Cer	tificate of L	Death	Reg. No.	26655
Physician	1. Decedent's Neme (First, Middle, Last)	0,5	<i>A</i> 1	2. Date of Month	Day Yea	3. Time of Death
/Medical	ANGELINA	KIFI		b. City, Town, or Location of D	21 200	
Examiner	4e Facility Name (If not institution, give street and number) BOX SECOURS A		AL	BALTIMO	RE	Hern
Funeral Director	5. Social Security Number 6. Sex 7. Age (1) 1. Security Number 1. Sex 1. M 2 XF 1. Usual Residence of Decedent	(In yrs. last birthday) 80 Yrs.	Months Deys	Hours Min. 8. Dete of (Month,	Birth Dey, Year) 9. 8 (30, 1920	Birthplace (State or Foreign Country) MD
P Bu		Oc. City, Town or Loc	cation	Real Park	781925	10d. Inside City Limits
with the Mary a or 28a-f shu be notified a	MD Baltimore	Towson				1 ☐ Yes 2 ☐XNo
or 28e-1	10e. Street and Number		10f. Zip Code		10g. Citizen of What (Country?
ath math	509 E. Joppa Road		2120		U.S.A.	merican Indien,
21215-0020 d within 72 hours after do plene. r than "natural", or itsem the Medical Examiner: completed by Funs	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, 3 No If Yes, Give Yeer or Dates:		Yes, specify Cuba	ispenic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify:	Black, WI	
5-0 72 ho 72 ho fical eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupe kind of work done of	etion during most of working)	16b. Kind of Busines	ss/Industry
I 2121 sed within yourse. yourse. we than the	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired Itress)	Clothing	
** 325H O	17. Father's Neme (First, Middle, Last)	Jedin	101 633	18. Mother's Name (First, Mid		
rland Mental H Mental	Ignazio Rifici		~	Frances	Guiffre	
and State	19a. Informant's Neme/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rural Route Nu	imber, City or Town, State	, Zip Code)
B, N and m 27	Marie Armstrong-Sister			Rd., Towson, I		
Pages 1	1X Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)	New Cathe	dral Ceme	etery 8/23/00		e, MD
Ball permit Depart import any in	21. Signeture of Funerel Service Licensee William G		Neme end Address	ss of Facility Leonard G rd Rd., Baltimo	J. Ruck Fune	ral Home, Inc.
	23a. Part 1. Enter the diseese, or complications thet caused the shock, or heart failure. List only one ceuse on each line.					Approximata Intervel Between
Physician /Medical		YEY M				Onset and Death
Examiner	resulting in deeth)	ue to (or as a conseq				1
je se se	- CHRON	11C /2	ENAL	FAILURE		
60, be executed ician and buriat-transit	0	ue to (or es a conseq	uence of):	EART FA	- 1400	
68760, filicate be execu- physician and as the burist-trained edical Exam		ESTIVE		EAR) FA	ILURE	
W = - = W	resulting in death) Last	e to (or es e consequ BETE	uence of):	MELLITUS		
Geath cert death cert e attendin de for use	Pert II. Other eignificant conditions contributing to death but r	not resulting in the ur	nderlying cause giv	en in Part I 23b. I	Did tobacco use contribu	ute to the cause of death?
P.O. that the ned by the detache		Tot Toda Mily III III o	Toony mg daddo giv		1 Yee 2 No 3	
COTC require been s should				24a. V	Vas en autopsy performed?	b. Were eutopsy findings evailable prior to completion of cause of deeth?
The ta				1	Yes 2 No	1 🗆 Yes 2 🗆 No
Vital Relationary Vital Relations of the law certificate hes irector, page 2 be Comp	25. Was case referred to medical examiner?	_		26. Place of Deeth (Check or	nly one)	
of Vita Physician: this certific ral director, TO Be	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 Nursing Home 5 L F		pecify)
aling P. Aftar t funera	27. Manner of Deeth 1 ☑Natural 5 ☐ Pending (Month, Dey Y	(ear) 28b. Time of Injury	28c. Injun Work	y et k? Yes 2 □ No	ibe how injury occurred	
Vision Attendar death actor: by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (r - At home, farm, stre (Specify)		28f. Locatio	on (Street and Number or Town, State)	Rurel Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 ☐ Certifying Physician: To the best of reference only 2 ☐ Medical Examiner: On the basis of ex	ny knowledge, death	occurred at the tin	ne, date and place, and due to	the cause(s) and manner	as stated.
the H thin 24 the F mplete	one) end manner stete	d.	29c. Licens		29d. Date signed (Mo	
5 × 5 × 5	29b. Signature and title of certifier	The.				
a	30. Nagre and address of person who completed cause of deal	th (thom 22a) (Time	Periot)	0 20377	ungeres	X/ 100E
0	ROSITA R. CRUZ	- M-	S'B	0N SECO	urs Ho	SPITAL
State Registrar	AUG 2 3 2000 Separation 32. Registrar's	D La	anka			



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Pages

Health Nam 27 I

Physician

/Medical

Examiner

Examiner

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Medicai

that the death certificate be executed pue Physician/Medical the Completed page 2 certificate has director. Be Certification: To this funeral After Attending after death the á 6

Physician

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Records, Division of Vital To the Hospital within 24 hours a To the Funeral (

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical exeminer? 1 Yes 2X No 28a. Dete of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred tnjury at Work? 1 Neturei 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State

vietelamos

DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

22 100

31. Date filed (Month, Dey, Year) AUG 2 3 2000

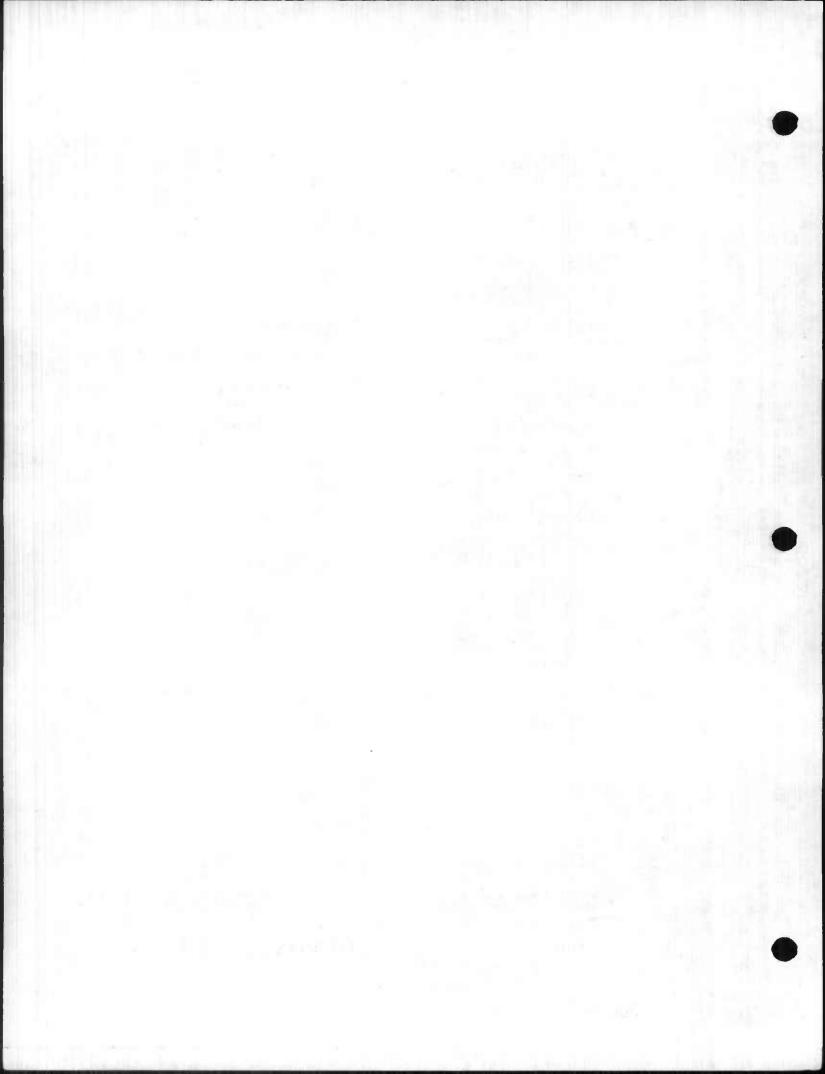
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30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Régistrer's Signeture

43725

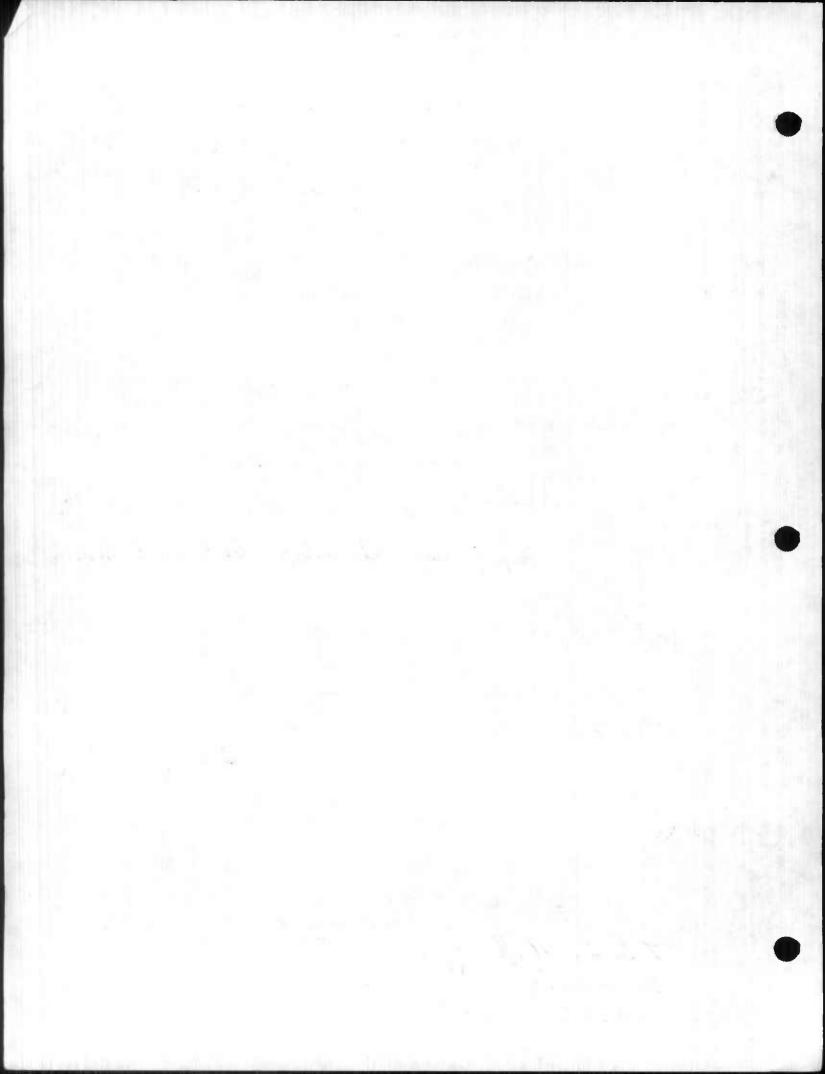
Registrar



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State of Maryland / Department of Health and Mental Hygiene

	ASP		Certificate of Death	Reg. No.	26657
	Physicia	1. Decedent's Name (First, Middle, Last)	1	2. Data of Death Month Day Yas	
46	/Medica	DEMAMIN FRANKL	IN SAVAGE	AUGUST 17 200	
	Examine	3800 W. BELVADERE AVE	4b. City, Town, or U BALT IMORE	E	NIA
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. In 1904 20 F 7. Age (In yrs. In yrs. In 1904 20 F 7. Age (In yrs. In yrs.	ret birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.		Birthplace (State or Foreign Country) 1 A R Y L AND
	myten dist		Town or Location		10d. Inside City Limits 125.Yes 2 □ No
	28e-f	MARY/AND N/A 10e. Syeet and Number AF	SALTI MOR	RECITY 10g/Citizen of What	
			7.208 10.20000 HICKUE -7 12 12	5 USA	
	death mms 2	11. Marital Status 1 Never Married 2 Married	6. 13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puart		mericen Indian, /hite, etc.
5-0020	Mr. o	3 Widowed 4 □ Divorced If Yes, Give Year or Datas:	1□ Yes 28 No Specify:	Specify:	BLACK
50	72 h	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Busine	ess/Industry
121	within then the Me	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) ATTGRAPE 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)	SERVICE MAN	VAGER BLUE C	OFET PATEOR
d	Hygi other ant, p	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumame)	CST CITIZAZA
/lar	Wanta Menta rhed file ev	BENJAMIN	SAVAGE SR. SAR	AH	JO HNSON
/an	2 sho and land is ma	19a. Informent's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Ru		
8, A	family fa	MARY CONER (GOD-DAUGHTER) 20e. Method of Disposition 20b. Pt.	1449 N. CAREY Stace of Disposition (Name of	Data 20c. Location - City	E. MD. 2/2/1
nor	ages nitol nor or	1 Rurial 2 Cramation 3 Permoval from State	metery, crematory or other place)		
Ħ	ortans ortans injury	4 Donation 5 Other (Specify) 21. Specify of Funeral Servin L.	RRISON FOREST 22. Name and Addrass of Facility	1 200 UWINGS	150 al Han
ñ	Deg man	Marian Mallima	22. Name and Address of Facility JOSE PH H. P. 2140 N. FULTO	ROWNUR. Fai	MERAL HOM
		23a. P. 11. Enter the disease, or complications that ceused the daath, a bek, or heart tailure. List only one cause on each line.	Do not enter tha mode of dying, such as cerdiac	or raspiratory arrest,	Approximate interval Between
	Physician				Onsat and Death
9	/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in deeth)	ine ather schotic	lege dio vos culo	hrem
		Due to (or	as a consequence of):		
	buted and ransit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last b. Due to (or	as a consequence of):		
0,	e axes	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury			
68760,	rificate be asscuted ng physician and as the burial-transit	that initiated events resulting in death) Last Due to (or	as a consequence of):		
ox e	- De				
0	v requires that the death ce been signed by the ettendit should be detached for use	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying ceuse given in Part I.	23b. Did tobacco uss contrib	outs to the cause of death?
0.0	d by the			1 Yes 2 No 3	Probably 4 Unknown
ds,	signe d be d			24a. Was an autopsy 24	4b. Wera autopsy findings
200	been should			performed?	available prior to completion of causa of death?
Records,	The law ate has begge 2 s	A gamenta de la companya de la compa		1 Yas 2 No	1 Yes 20 No
	ysician: The li is certificate ha director, page	25. Wes case referred to medical	26. Place of Dea	ath (Check only one)	74
Division of Vital	Physician: r this certific ral director,	1 Yes 2 No Hospitel: 1 Inpatient 2 E	the state of the s	lome 5 ☐ Residence 6 ☐ Other (S	Specify) SCENE
S C	Affect I	27. Manner of Death 28e. Date of Injury (Month, Day Year)	28b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	
Sign	Attending or death. ector: Afte by the fune	A Coident invastigation Could not be determined 28e. Plece of Injury - At hood	me, ferm, street, factory, office	28f. Location (Street and Number of	r Rural Route Number,
á	al or a safe	27. Nanner of Death 27. Nanner of Death 5 Pending invastigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At how building, etc. (Specify,		City or Town, State)	
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of axaminati and manner stated.			
	withir To th	29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (M	
	, 1	Therdy M. King	O.C.M.E	AUGUST 1.8	3,2000
	5	1	23a) (Type, Print)		7.04000
	/	31. Date filed (Month, Day, Year) 32. Registrar's Signate		Baltimore, Maryl	land 21201
	State Registra	AUD 0.9 2000 A	& Sparks		

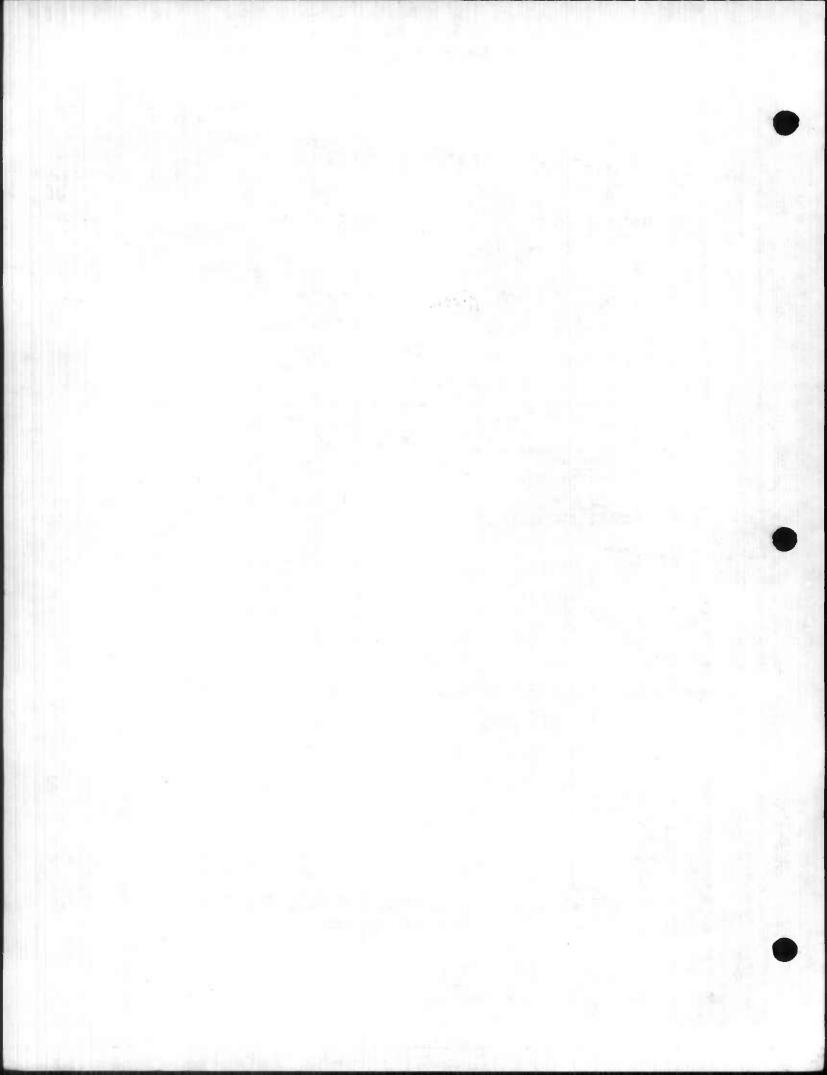


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Smith AlbeRT LINWOOD 8 11:58 Pm Aug 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randaelstown CHAPEL HILL NursiNG CENTER Backmore If Under 24 Hrs. 7. Age (In yrs. last birthday) & Yrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days 213-28-9895 Months 12M 20 F Director April 11,1932 Maryland **Usual Residence of Decedent** 10b. County 10a. State 10c. City, Town or Location 10d. tnside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Nes 2 No Baltimore Director Marchand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ready Ave 5209 permit. Pages 1 and 2 should be filled within 72 hours after death w Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ratural", or Itama 23s and any lightly or other traumatic event, the Legical Section 1885. U.S.A, 21212 Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?
1 Dives 2 No.
If Yes, Give
Year or Detes: No Can Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 2 No Baltimore, Maryland 21215-0020 Specify: BLACK Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry METAL Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER TRUCK 12th NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SM ITH William BROWN Olivia 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5209 Ready Ave. Batto, nd. 21212 SON Alvin G. Scott -20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 128 Burial 2 Cremation 3 Removel from Stete 8/24 OWINGS MILL, MD. 4 □ Donetion 5 □ Other (Specify) Garrison Forest Vet. 100 21. Signeture of Funeral Service Licensee Lewis T. Guynn 22. Name and Address of Facility T. Gwynn Funeral Home Parkheights Are. Bretv. nd. 21215 4517 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) Monbosis /Medical Cerebral Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or ea a consequence of): and the attending physicien the dor use as the burle that initieted events reaulting in death) Last Due to (or as e consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Nonknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 tnpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: After Division or Attending 5 Pending investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu death 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Da 7683 8/23/00 Tayman Milli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millo Resolver 25 Man Street 2000 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Ray 6/95

State Registrar

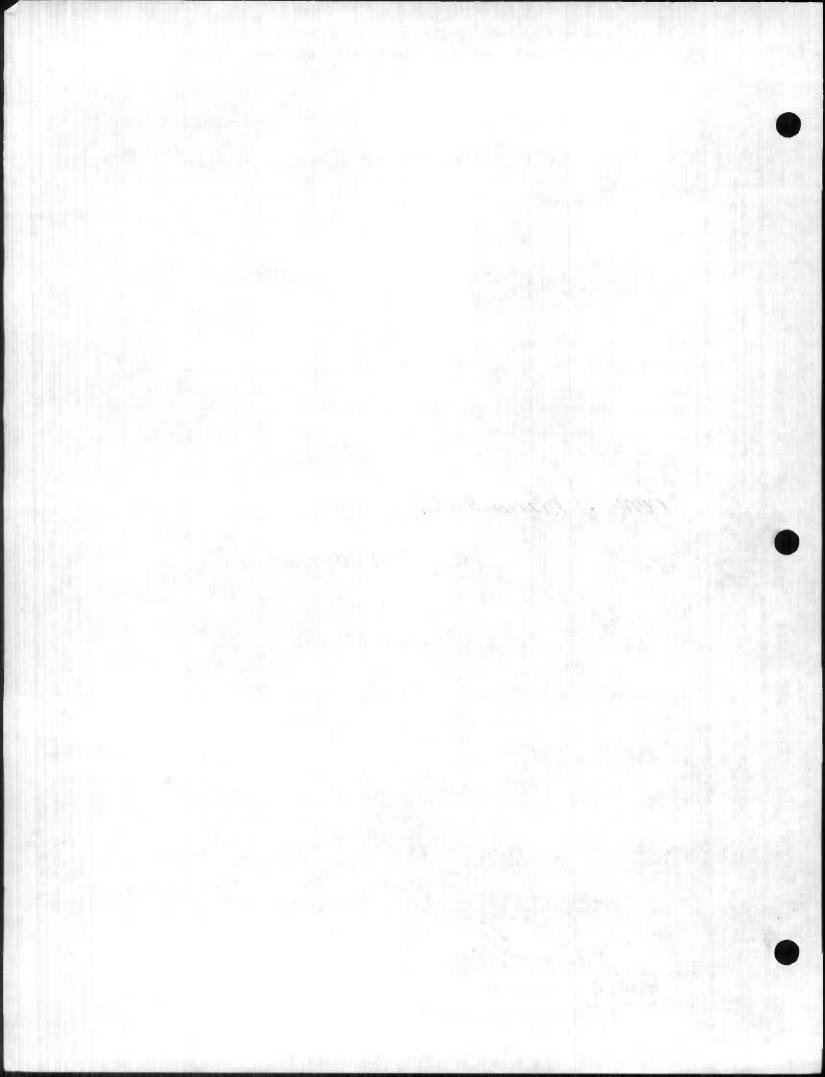


00-4745-510 JAMES T SMART

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State of Maryland / Department of Health and Mental Hygiene 00 25659

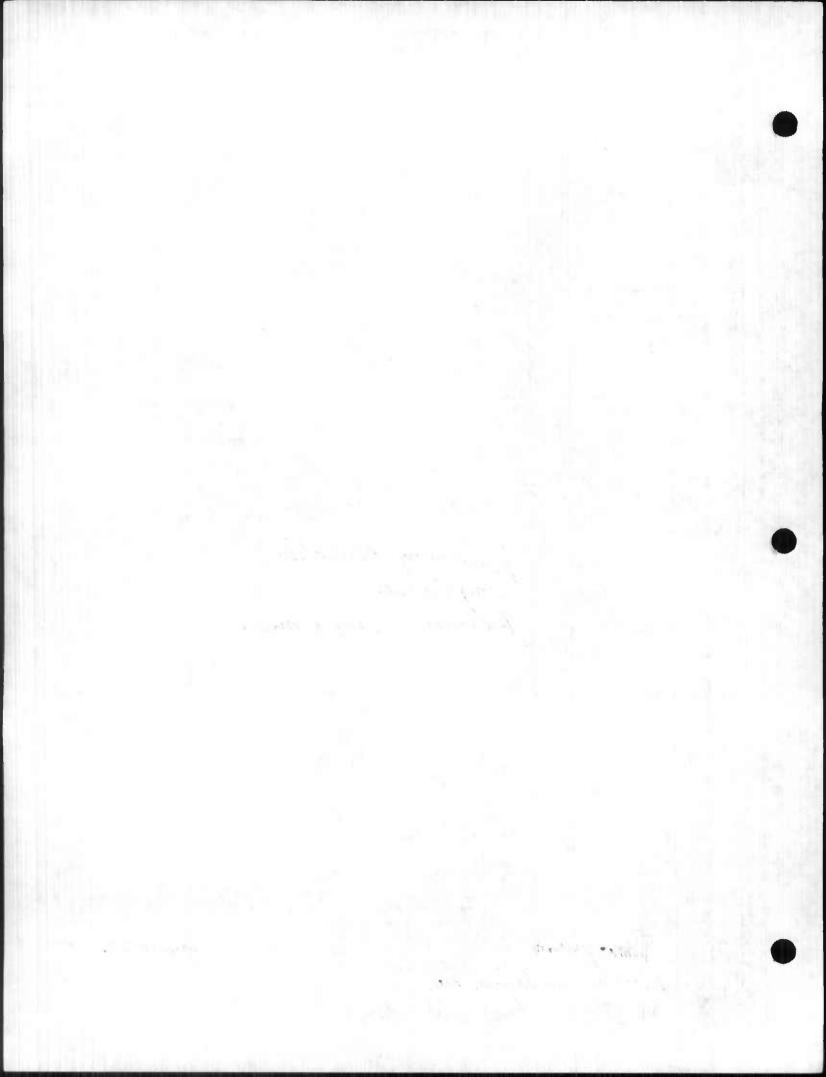
JVW				Ce	rtificate	e of	Death		Re	g. No.	0 6	.00	JJ
	Physician	Decedent's Name (First, Middle, La							2. Date of Death Month AUGUST		2000	3. Time o	of Death 38 A.M
	/Medical Examiner	James Thomas 4a Facility Name (If not institution, given SHOCK TRAUMA						wn, or Lo	ocation of Death	4c. County	of Deeth		
	Funeral Director	334 20 7403	Sex 7. Ag	ge (In yrs. last birthday 17 Yrs.) If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Birth (Month, Day, May 16.		9. Birthpt Count Flori	-	or Foreign
	Maryland a-f show filed.st	Usual Residence of Decedent 10b. County MD. Howard		10c. City, Town or L	ocation						10	Od. Inside (City Limits
	ar death with the Maryla thame 23a or 28a-f shor mer mast be notified at uneral Director	10a. Street and Number 15430 Roxbury Roa	ad		10f. Zip	Code			10	U.S.A	What Count	ry?	
020	uraf, or items it Examiner m d by Funer	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes Yes If Yes, Give Yeer or Detes:		Was Decedif Yes, spec			gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	Bla	ck, White, e	etc.	
21215-0020	77 mat adjournment	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	edent's Usue e kind of wor DO NOT us	l Occur k done e retire	pation during mos ed)	t of work	ring	16b. Kind of B	usinass/Ind	ustry	
Maryland 21	be fied withing tal Hygiene. d other than event, the Me	11 17. Father's Name (First, Middle, Last,	122-1-1-1		dent		18. Mothe	er's Nam	e (First, Middle, N		udent		
100	To the standard of	William T. Smart					Elai	ne I	. Appoll	loneo			
an	offe man	19a. Informant's Name/Relationship (Type, Print)	19b. Mel	ing Address	(Stree	t and Numb	er or Rui	ral Route Number,	City or Town	, Stete, Zip	Code)	
altimore, M	Pages 1 and 2 nent of Health. Int. If Item 27 is any or other tre	William T. Smart 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremefion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications)	Removel from State	20b. Place of Disp cametery, cre	osition (Name matory or of	ne of ther pla	aca)		Lenwood, 2018/24/200	20c. Location	- City or To	wn, State	
68760,	the death certificate be axecuted by the attending physician and ached for use as the bunel-transit ached for use as the bunel-transit arrangements by sician/Medical Examiner	23a. Pagt. Enter the disease, or come shock, or heart failure. List only immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in death) Last			equence of):	e of dy	ing, such as	cardiac				Approxima Interval Be Onset and	ate M
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of Vital Records	has been s ge 2 should mpleted									ection	cor	ere autopsy alable prior apletion of death?	r to f cause
a	certificate har rector, page	05.111							1 □ Ye	,	11	Yes 2	
5	Physician; this certific ral director.	25. Was case referred to medical examiner?	Hospital:	. Af		. 0	ther:		th (Check only on				
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	n 24 house the Funer pletely fil	(Check only 2 Medical Example)	niner: On the basis o	f examination and/or is	nvestigetion,	in my	opinion, des	th occur	red at the time, de	ete and place,	, and due to	the cause	(a)
	To the Hospital within 24 hours a To the Funeral C completely filled	295. Signature and title of certifier	2	n.p,	29c		o.C.M.	E.	2	9d. Date signe AUGUS			
	AB.	30. Name and address of person who	completed cause of o			stre	et, B	alti	more, Ma	ryland	2120	1	
	State	31. Date filed (Month, Pay, Xear) 3		as Signature	B	lo	n Va						



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State of Maryland / Department of Health and Mental Hygiene

		Certi	ficate of Death	Re	g. No.	0 26660
Physician	1. Decedent'a Neme (First, Middla, Last)	C .	11	2. Dete of Deat	h Day	3. Tima of Death
/Medical	James	OMIT	th	Hugust	- 19 3	cw 11.08PM
Examiner	4a Facility Nema (if not institution, giva street and numb	er)	4b. City, Town, or	Location of Death	4c. County	of Deeth
	The Johns Hopk	INS HOSPIT	If Under 1 Year If Under 24 Hrs	noneut	4	
Funeral Director	217-70-2414 X M 2DF		Months Days Hours Min			Birthplaca (Stata or Foreign Country) MARYLAND
D 2	Usual Rasidance of Decedent 10a. Stata 10b. County	10c. City, Town or Local	tion			10d. Insida City Limits
f sho	MARYLAND N/A	BALTI	MORE			1 X Yas 2 □ No
th with the Maryla 23e or 28e+ show ust be notified at rai Director	10e. Street and Number		10f. Zip Coda	10	g. Citizan of W	hat Country?
Sa o si D	1125 N. BOND STREE	r	21213	D 5	U.S.A.	
ar, or hams Examiner in by Fune	11. Marital Status 1 Nevar Merried 2 Married 1 Nevar Merried 2 Married 1 Vidowed 4 Divorced 12. Was Deceda Armed Force 1 Yas 2 H Yas, Giva 7 yaar or Daté	□No	is Decedant of Hispanic Origin? (s' 'as, specify Cuban, Maxicen, Puar Yas 2 No Specify:	Specify Yes or No- to Rican, etc.)	Black	- Amaricen Indian, k, Whita, atc. - AMERICAN
2 ho	15. Decedent's Education	16a. Deceder	nt's Usual Occupation	deina	16b. Kind of Bu	sinass/Industry
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To the Hospital of Within 24 hours all to the Funeral D completely filled in Medical Ce	29a Certifier 1 Certifying Physician: To the be	est of my knowledge, death o	occurred at the time, date and place	e, and due to tha coursed at the time. d	ausa(s) and ma	nner as stated. and due to the cause(s)
the F the F the F	end manner					
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in	Momagyum		Kes - 000	1	prest	22,2000 Mangland 11,000 2128
M.	30. Name and addrass of person who completed cause of	of death (Item 23a) (Type, Pr	int)		0	Manglano
CKA	Michael Van Rooyes	u, mo 600	North Wood	e STLEE	T balt	1 more 2128
State	31. Deta filed (Month, Day, Year) 32. Reg	istrar's Signature	-			
	AND THE COURT OF THE PERSON OF	61 .011	I CHA IT A			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthug. 2000 SOPHIE K. SCHROEDER 5:30 PM 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ivy Hall Nursing Home Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Vrs 80 Balto. City.Md 220-48-2605 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Perry Hall Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9862 Belair Rd 21128 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bisck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry N / A College (1-4or 5+) Elementary/Secondary (0-12) Clerk Balto. County Court House years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Thomas Kowall Jennie Lazaruk 19a. informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie E. Williams (daughter) 8110 Bradshaw Rd. Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 8/22/00 Bel Air, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Feclify E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087 J. Lassa M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntarval Between Onset and Death immediate Cause (Final disease or condition resulting in death) accident Cerebro vasculen Due to (or as a consequence of): Amal Franklatin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Diabeles Due to (or es s consequence of): brownie 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were sutopsy findings svaliable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2₽No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 26b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No

Division of Vital Records, P.O. Box 68760 e Hospital or Attandi n 24 hours after death. Ne Funeral Director: A

law requires that the death certificate be executed

or Attanding Physician:

Physician

/Medical

MD

Director

Funeral

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Examiner

Funeral

Director

"natural", or items 23a or 28a-f ahow

permit. Pages 1 and 2 should be filed within 72 hours after death with 1. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 2 and hydrighty or other traumatic avent, the Meaner Exercises on 20.00.

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Certification: To

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Baltimore, Maryland 21215-0020

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Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Wss case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 5 Pending investigation 1 Natural 2 Accident 3 Suicide 6 ☐ Could not be 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 29a. Certifler 2 Medical Examiner: On the besis of examinetion snd/or investigation, in my opinion, deeth occurred at the time, date and pisce, end due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

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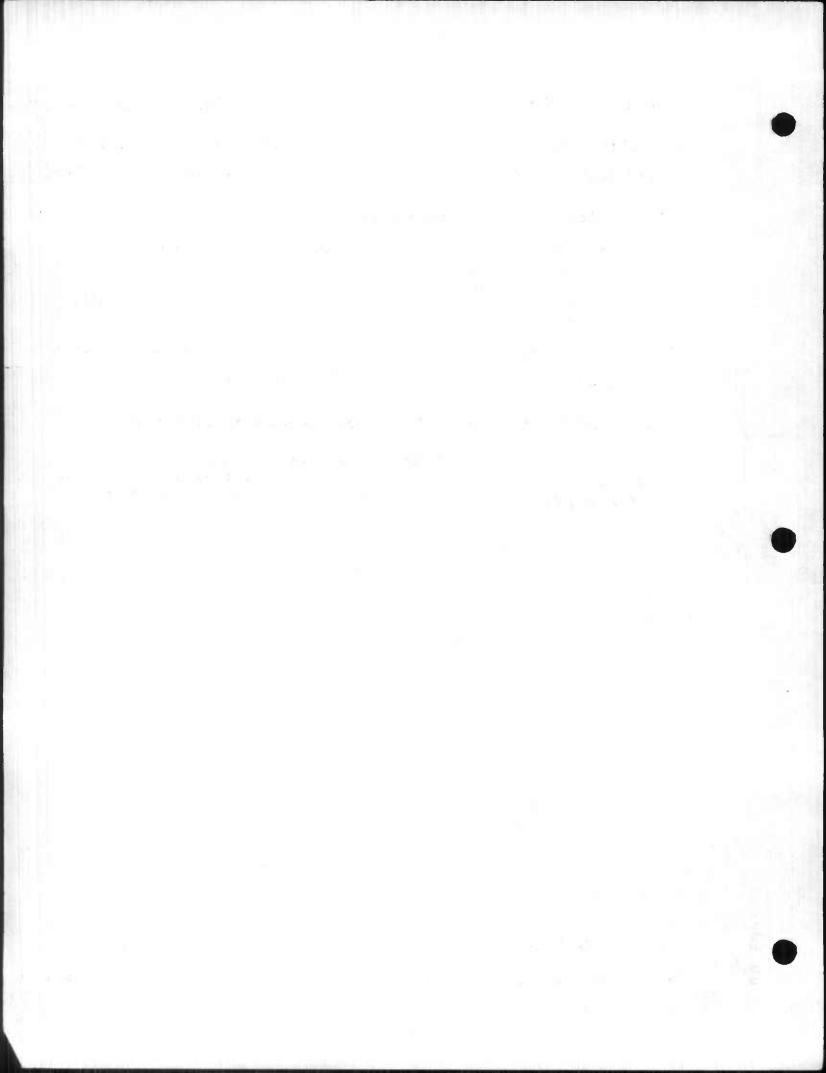
To the P

31. Date filed (Month, Day, Year) AUG 2 3 ZUUU Registrar

allow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Entens St Junte 308 13alt. MD HAS Ami 821 32. Registrar's Signature Darks



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6.6.6.2 3. Time of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Mathew Slodzinski August 20, 2000 8:25 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 4620 Charles Avenue Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Months | Days | Hours | Min. | March | 24, 1927 | Poland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 12 M 2 F 73 213-30-0456 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 200 No 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? 4620 Charles Avenue 21206 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 ⊠ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Valente Slodzinski Katarina (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Elizabeth Slodzinski/Wife 4620 Charles Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, Stata etery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Saint Joseph's Cemetery 8/23/00 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sa John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 23a. Part 1. Enter the dr. shock, or heart fall arrest, and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOPULMONARY disease or condition resulting in death) Due to (or as a consequence of): ARDIAC ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to 24a. Was an autopsy VASCULAR completion of cause of death? 1 Yes ZANO 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner I or Attanding Physician: The law requires that the death certificate be executated death.

Director: After this certificate has been signed by the attending physician and in by the lunarial director, page 2 should be detached for use as the bunial-trant. P.O. Box 68760. Physician/Medical Division of Vital Records, Be Completed by edicai Certification: To To the Hospital or Attain 24 hours after der To the Funeral Director Completely filled in by the

Physician

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Examiner

MD

Funeral

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23s or 28s-f show must be notified at

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If Itam 27 Ia marked other then "natural", or he

Department of Important: If any injury or

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

Be Completed by

death with the Manyland

27. Manner of Death 1 Salatural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending Investigation

6 Could not be determined

-UD

1 Yes 2 No 28e. Place of fnjury - At home, farm, streef, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Dafe signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH HALLORAN MD DEH RAVEN BLVD BALTIMORE MA

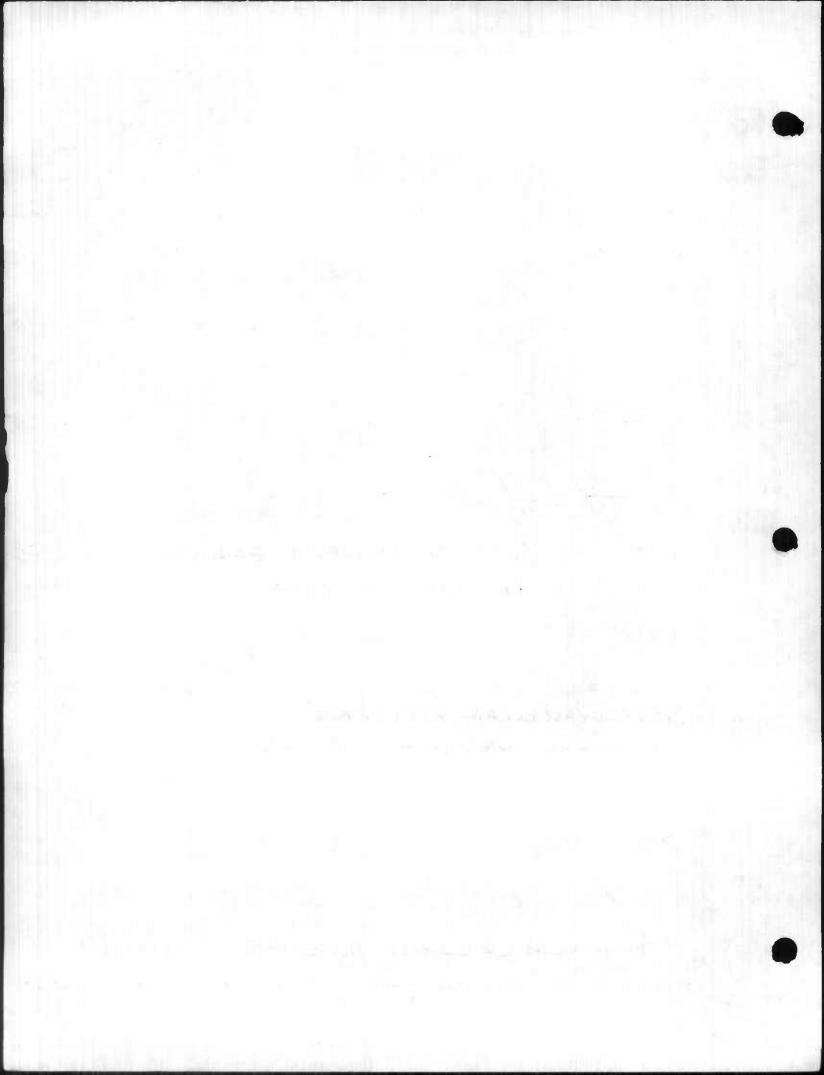
31. Date filed (Month, Day, Year)

32. Registrar's Signature AUG 23

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Loretta Smith ZVelyn 4b. City, Town, or Location of Death 20 2000 6420am /Medical 4a Facility Name (If not institution, give street and number, 4c. County of Death Examiner N/A Harbor Hospital Centur Bulhmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Monfhs 1 M 2 X F 214 14 1579 Yrs. 83 Director Nov. 18, 1916 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show flem 27 is marked other than "naturel", or flems 23s or 28s-f sho other treumstic avent, the Medical Examiner must be notified at 1 Yes 2X No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 Gallatin Way 21122 U.S. Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Americen Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. 12th Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Nem 27 is marked other any injury or other treasment. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Hanora Kearney Joseph Kestler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John Smith 804 Bentwillow Drive Glen Burnie, Maryland 21061 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pleca) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stafe 8/24/00 Lakeview Memorial Park Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway 21225 Baltimore, Md. romerouse tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or couple shock, or heart failure. List on the couple of the couple o Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Kespiratora Examiner Physician/Medical Examiner signed by the attending physician and the detached for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. wngcancer that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 1 No 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatienf Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ☐ ER/Outpatienf 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural ours aftar death. neral Director: Af 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could nof be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

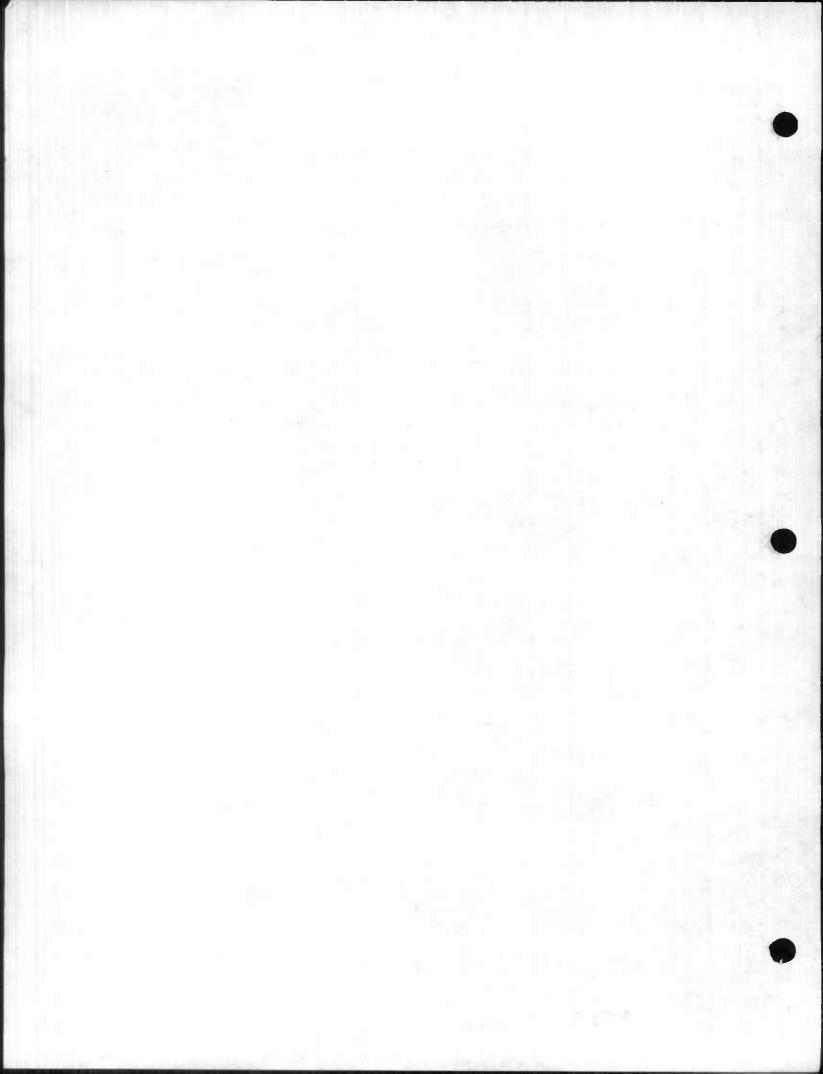
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and fittle of certifier 0 August 20 2000 ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ammy RBenton Harbor Hosvital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

DHMH 16 Rev 6/95

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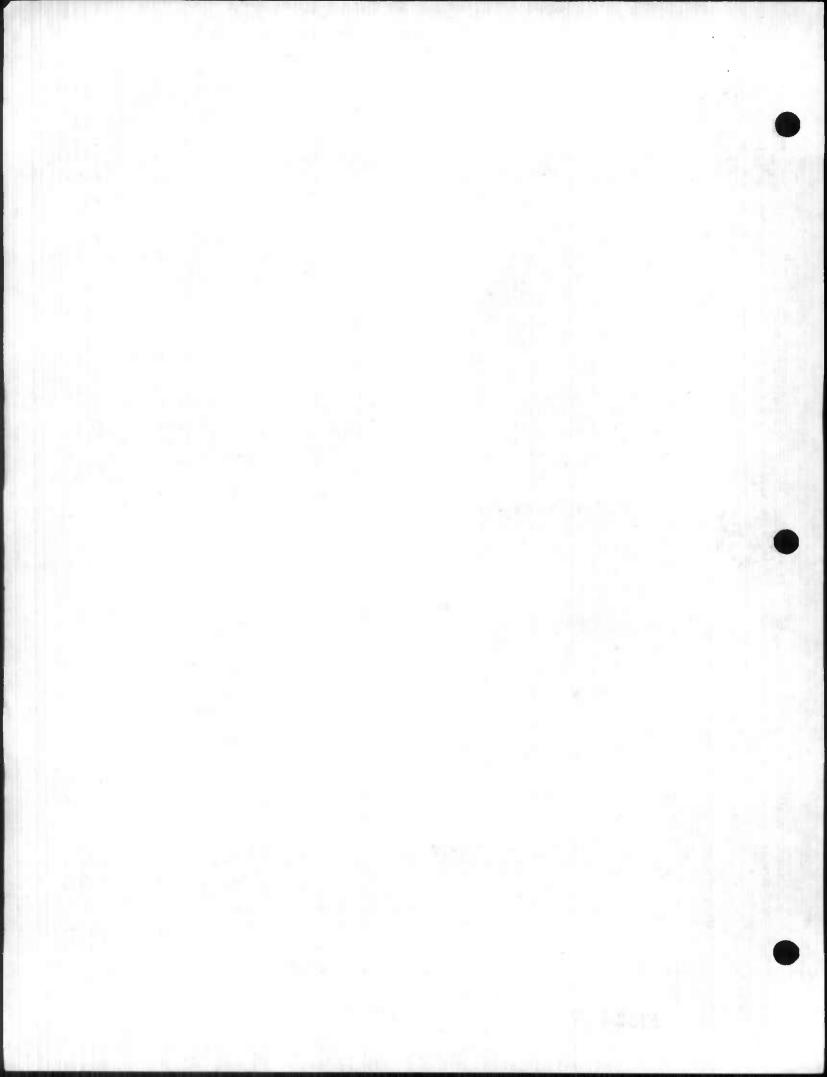
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State of Maryland / Department of Health and Mental Hygiene

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Vision Attending or death. ector: After by the fune	2 Accident invastig	ot be	000		/\	30	nieg	roy
Division or Attending after death. Director: After dir by the fune	1 AomicIde determi		fy) farm, st	tectory, office	,	City o	r Town, Stete)	ber or Rurel Route Number,
O paragraph		Continue visc	STR	-661		3600	BEDY	1 mms ove
papi hou iner iy fill	29e. Certifier 1 Certifying	Physician: To the best of my kn						
Div To the Hospital or A within 24 hours after To the Funeria Direct completely filled in D Medical Certit	2LAMedical E	maminer: On the basis of examiner and menner steted.	ation and/or in	vestigation, in my	ориноп, оее	ALL OCCURRED OF THE L	ine, date and place,	end due to the cansa(s)
within the company of	29b. Signature and title of certifier	Λ		29c. Licen	sa number		29d. Data signe	ed (Month, Day, Year)
F > F 0	De gat	sho ma			OCME		AUGUS	r 18, 2000
		. 4.5	100					
0	30. Name and address of person v				Dall	timore 1	and and a	1201
V	1. MARON (A	, par	сшюге, м	aryland 2	1201
State	31. Data filed (Month, Dey, Year)	62. Registrar's Sign	etute	Sporks				
Registrar	AUG 2 3 200	June 1	/ /					



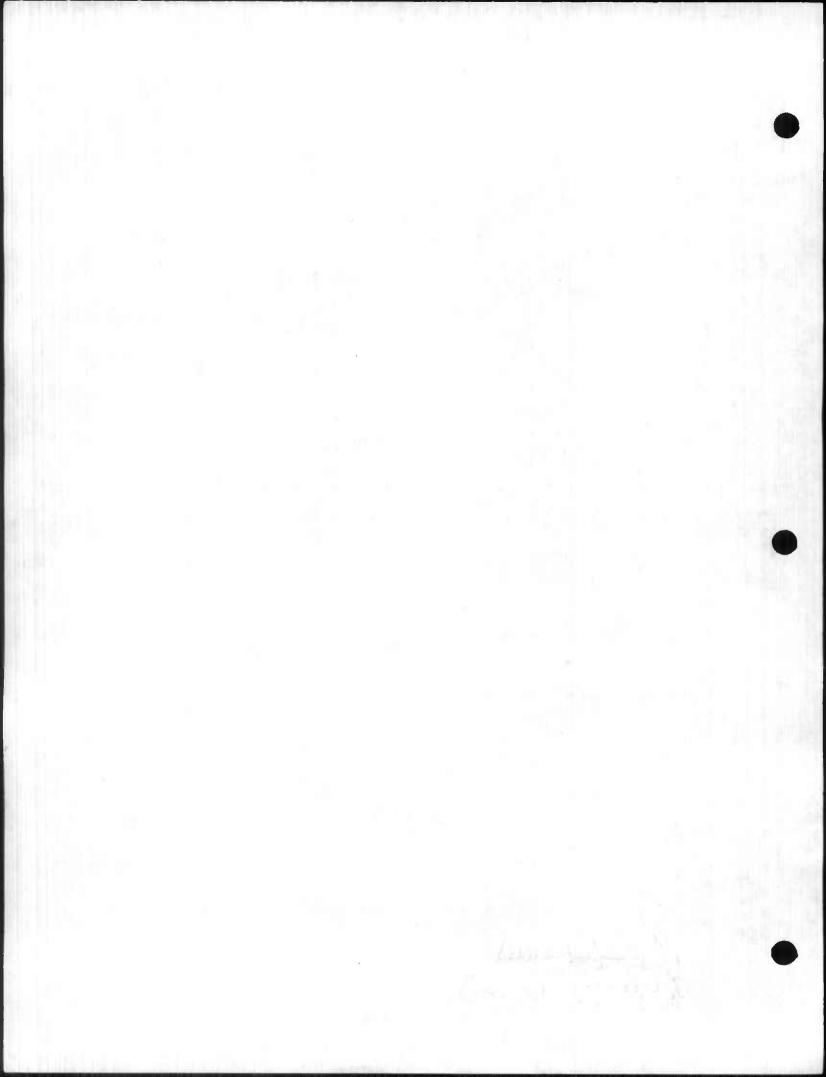
end item 1,23a	HONY SYDNOR 1, b, 27, 28a, b, c, d, f, e per 1. Decedent's Name (First, Middle, L				te of	Death		2. Dete of Dea	Reg. No.		3. Time of Death	
Physician		Darius Mich	nony Syana	or				Month AUG.	Day 200	Year	0810 AM	
/Medical	DARUIS ANTHONS 4a Facility Name (If not institution, gi					4b. City, To	wn, or Lo	cation of Death			0010 AM	
Examiner	ST.AGNES HOSPI					BALTI	IMORE	3				
Funeral		Sex 7. Age	(In yrs. last birthe		er 1 Year	If Under			h Veer)	9. Birthpl	ace (State or Foreign	
Director	219-57-2999	M 2□ F	Yr	s. Months	Deys	Hours	MITT.	8. Date of Birt Month, Day 06 09	2000	Mayla	and	
2 .	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town of	or Location						110	Od. Inside City Limits	
fanyta fanyta est at	Maryland N/A		Baltim								1 Yes 2 No	
eath with the Maryla ns 23s or 28s-f shor must be notified at eral Director	10e. Street and Number		Darcin		ip Code	-			10g. Citizen of W	/hat Count	iry?	
at he	47 Birdnest Cou		212	27			TI C 3					
flar death w r flams 23a siner must b	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Was Dec		igin? (Spe	ecify Yes or No- Rican, etc.)	U.S.A	- America k, While, a			
	1 Never Married 2 Married	1 Yes 2 No		1 Yes				riican, etc.)	Specify	D1	ack	
d by	3 Widowed 4 Divorced	Year or Dates:										
ed within 72 ho ogiene. we than "naturn 4, the Medical. Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. D	ecedent's Us Give kind of w fe. DO NOT	ual Occu rork done	pation during mos	t of worki	ing	16b. Kind of Bu	siness/Ind	lustry	
werns ens. than	Elementary/Secondary (0-12) N/A	College (1-4or 5+)			/A	,,,			N/A			
the filed of the desired of the desi	17. Father's Neme (First, Middle, Las	n)				18. Mothe	er's Name	(First, Middle,	Meiden Sumam	e)		
Mad herita herit	LaKeshis Hintor	n				Mosi Sydnor						
Mary itana ZIZIS-UUZU d2 should be filed within 72 hours at h and Merital Hygiens is h and Merital Hygiens is traumatic event, the Medical Exam To Be Completed by 8	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number or Run						er, City or Town,	State, Zip	Code)	
- 6 1 N b	LaKeshia Hintor	n/Mother				Ct., I	Balti	- T	Maryland			
Pages 1 ent of Hs ntt if Hen ry or oth	20a. Method of Disposition 1 Suriel 2 Cremation 3	Removal from State	20b. Place of D cemetery,	erematory or	ame of other ple	эсе)		Date	20c. Location -	City or To	wn, State	
The Page (Jury (Jury)	4 Donation 5 Other (Spec	ity)	Mt.	Zion C				3/21/00	Lansdow	ne, l	Maryland	
med med mine	21. Signature of Eurotical Strvice Lice	grey				ess of Facilit						
402.0	23a. Paryl. Epiecthe disease, or co	Laur							y Funera			
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a. ASPHYXIA D	ue to (or as a co	nsequence of	():							
be avacuted claim and bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	ue to (or as a co	nsequence of):		E					
P.O. BOX 68760, at the deeth certificate be awd by the attending physician eleched for use as the bunal Physician/Medical Ex	Cause (Disease or injury that initiated events resulting in deeth) Lest	CDu	ue to (or as a co	nsequence of								
Clar Clar	Dort II. Other algoritisant conditions		23b. Did tobacco use contributs to the cause of death?									
Phy the Cotache	Part II. Other significant conditions	contributing to death but	not resulting in t	ne underlying	ceuse g	IVOIT III FAILT		1 🗆	_/		pably 4 Unknown	
sw requires s been sign 2 should be								24a. Was perfo	an eutopsy rmed?	ava	ere autopsy findings allable prior to mpletion of cause death?	
- 6a O								100	Des 2□No	10	es 2□ No	
ysician: The secretificate director, pag	25. Was cese referred to medicel examiner?				1 =		e of Deet	h (Check only o	one)			
T digital	1X Yes 2 No	Hospital:			JUA		-		dence 6 Oth			
or Attending P after death. Director: After I d in by the funen ertification:	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigati	0/10/			28c. Inju Wo	ork? Yes 2353	kNo	infant			her overlayed	
be or Attending P is after death. In Director: After ted in by the funers Certification:	3 Suicide 6 Could not determine	28e. Place of Injury building, etc. residence		n, street, facto	ory, office				Street end Numb wn. State) 47] e, Marylat		of Route Number, st Court	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	hysician: To the best of aminer: On the basis of e end manner state	xaminetion and/	death occurre or Investigation	d at the t	ime, date ar opinion, dea	nd plece, ath occurr	and due to the red at the time,	cause(s) and ma date and place,	anner as si and due to	tated. the ceuse(s)	
To the comp	29b. Signature and title of certifing	Pm.s		2		o.C.M.	E		29d. Date signe AUG •	17,		
	30. Name and address of person who MARY G. I	CIPPLE, MI	2 111 F		reet	, Bal	timo	re, Mar	yland 21	1201		
State Registrar	31. Date filed (Month, Day, Year) AUG 2 3 2000	32. Registrar		boxx								



00-4090-041 cm John

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Inuciaian	1. Decedent's Nem									2. Date of D Month	Reg. No.	Yeer	3. Time o	Death	
hysician /Medical	JOHN T	ROUT								July		2000	3:35	P.M.	
Examiner	4a Facility Name (r Location of Dee					
	Easton M		l. HOSDI 6. Sex		na /In vrs	last birthday)	If Und	er 1 Yeer	Easto			bot	laca (Stata	or Foreign	
neral ector	unk Usuat Residence of			1⊠M 2□F 47 Yrs. Months Deys					Hours Mi		ay, Year)	Coun	iaca (State ((ty) K	or r orongri	
al Director	10a. Stete	10b. County			10c. Cit	, Town or Loc	cation					10	Od. Inside C	ity Limits	
ctor	MD	Talbo	t			East	on						1 ☐ Yes	2X No	
Directo	10e. Streef and Nui	mber					10f. Z	ip Code	4 7 6	W 165	10g. Citizen of V	What Coun	fry?		
		Harriso			Francis II	0 40 1			21601	(Cit- VN	USA	a - America	an Indian		
by Funeral	11. Maritel Status 1 Never Merri 3 Widowed		ed 1 G	s Decedent ned Forces? Yes 2 Des, Give er or Detes:				ecify Cubi	Specify:	(Specify Yes or N erto Rican, etc.)	Specify	ck, White,			
Completed	(Spec	15. Decedent'	's Education t grade comp	ducation 16a. Decedent's Usual Oc					during most of w	vorking	16b. Kind of Bu	usiness/Ind	lustry		
omp	Elementery/Seco	ondary (0-12)	Coll	lege (1-4or: unk	5+)	me. D		nk	0)			unk			
Be C	17. Fether's Neme	(First, Middle, L	Last)						18. Mother's N	eme (First, Middle	e, Maiden Suman				
To B	unk								un	ık					
	0.C.M.F		nip (Type, Prir	19b. Mailing Address (Street and Number or Rural Route 111 Penn Street Baltimo									Code)		
	20a. Method of Dis 1 Burial 2 4 Donation	Cremation		from State	C	lece of Dispos emetery, crem			ce)	Dete	20c. Location -	City or To	wn, Stete		
	21. Signature of Eu	onald S	Wade	Dir	ecto					ard 655 1201	W. Balt	imore	Stre	et	
dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or thet inilieted events resulting in death yi	trijury	b		Due to (o	r as a consequence of as a consequence as a consequence of the consequ	uenca of):			G PHYSICA				
Physician/Me			d												
ysici	Pert II. Other signif	icant condition	ns contributin	g to death b	ut not resi	ulting in the un	derlying	cause giv	ven in Part I.	23b. Dic	d tobacco uss co	ntributs to	the causs	of death?	
by Ph	HEAD	INJURI	IES							1 -	Yes 2 No	3 Prot	pably 4] Unknown	
Completed										24a. Wa per	s en eutopsy lormed?	ave cor	ere autopsy allable prior mpletion of death?	to	
E O										1/4	Yes 2□No	D	Yes 2] No	
Be	25. Was case refer examiner?	red to medical	11					l au		eath (Check only	one)				
	1 XYes 2 ☐ 27. Menner of Deat		Hospital	1 ☐ Inpation	-	ER/Outpatient		NOA		7	sidence 6 Oth		y)		
To	1 Naturel	5 Pending investig	ation 7	(Month, De	(Vear)	2:30	Р	28c. tnju: Wo 1 🗆	rk? Yes 2 No	SUB	JECT ASS	AULTI	ED		
	2 Accident	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify).								CENTER,	281 Location (Street and Number of Street Emilian CENTER Town, \$150) WEST BOVER STREET ON EASTON, TALBOT ON MD 21601				
Certification:	3 ☐ Suicide XIX Homicide	determi	-									297 Sec. 2011 Sec. 1997	He East	1000	
Certification:	3 Suicide	determing	Physician: examiner: On	To the best	f examinal						e cause(s) and mo e, date end plece,			s)	
	3 ☐ Suicide XIX Homicide	determing 1 Certifying 2 Medical E	Physician: examiner: On	To the best the basis o	f examinal		estigatio	on, in my o	opinion, death oc se number		, date end ptece, 29d. Dete signe	and due to	o the ceuse(s)	
pletely filled in by the funera edical Certification:	3 Suicide NIX Homicide 29a. Cantillar (Charles) 29b. Signature and	determing 1 Certifying 2 Medical E	Physician: Examiner: On and	To the best the basis of manner st	f exa <i>m</i> ina ated.	ion and/or inv	estigatio	on, in my o	opinion, death oc		, date end ptece,	and due to	o the ceuse(s)	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per phys. G786 8/23/00 yg Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Yaar Month **Physician** 9:55 om 4a Facility Nama (If not institution, give street and number) 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYAUN monto omeny OLNE HUSP47AL MONTGOMERY GENERAL If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 1 M 2 S.F Hours Director 466-16-4731 Usual Rasidence of Deceda 01/13/1913 Texas the Maryland 10d. Inside City Limits 10a Steta 10h County 10c City Town or Location r 28a-f ahow rectified at 1 Yas 2 No Director Gaithersburg Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "netural", or items 23s or solical Examiner must be 20882 USA death Funeral 5313 Brookville Road 12. Was Decedant Evar in U,S.
Armed Forcas?
1 ☐ Yas 2 ☒ No
If Yas, Giva
Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Ricen, atc.) 14 Race - Amarican Indian Black, Whita, atc. 72 hours after 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 NWidowed 4 □ Divorced White Completed th and Mental Hygiena.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Haalth and Mental Austin Merrick Annie Howell 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Haalth em 27 I Jon A. Teates/ Son 11468 Hanover Courthouse Rd, Hanover, Va 23069 if item 27 or other 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1≅Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: if any Injury or angle. 4 ☐ Donation 5 ☐ Othar (Specify) 08/06 Grace UMC Cemetery Stafford, VA 22. Nama and Addrass of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228
23a. Partf. Enter the dischase or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fails. Approximate intarval Between Onset and Death **Physician** SMAYS /Medical fmmadiata Ceuse (Finel RESPIT ATONY FAILURE disaase or condition resulting in daath) Examiner Due to (or es a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last end -tran Dua to (or as a consequence of): physiclan e s the buriel-Box 68760. Physician/Medical Dua to (or as a consequence of): attending pl signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown CHAONIC OBSTRUCTEDE PULMMANY PUSHA à 24b. Wara autopsy findings avallable prior to 24e. Wes an autopsy Completed I AN TRICULAR HYDESTROPHY completion of causa of daath? ils certificete has I 200 No 1 Yes 2 No 1 Yas Division of Vital Physician: Be 25. Was cese raterred to medical MONTGOMERY GHOVERAL 26. Pieca of Daath (Check only ona) 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yas 2 No this funeral 28c. Injury at Work? Certification: 27. Manner of Death 28d. Dascribe how injury occurred After Attending 1 Netural 5 Pending Invastigation 1 Yas 2 No deeth. 2 Accidant or Attendation of Director: 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and place, and due to the causa(s) and menner as stated.

2 Madical Examiner: On the best of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) 29a. Certifier Medical (Check only one) and mannar stated. 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifiar 29c. Licensa number

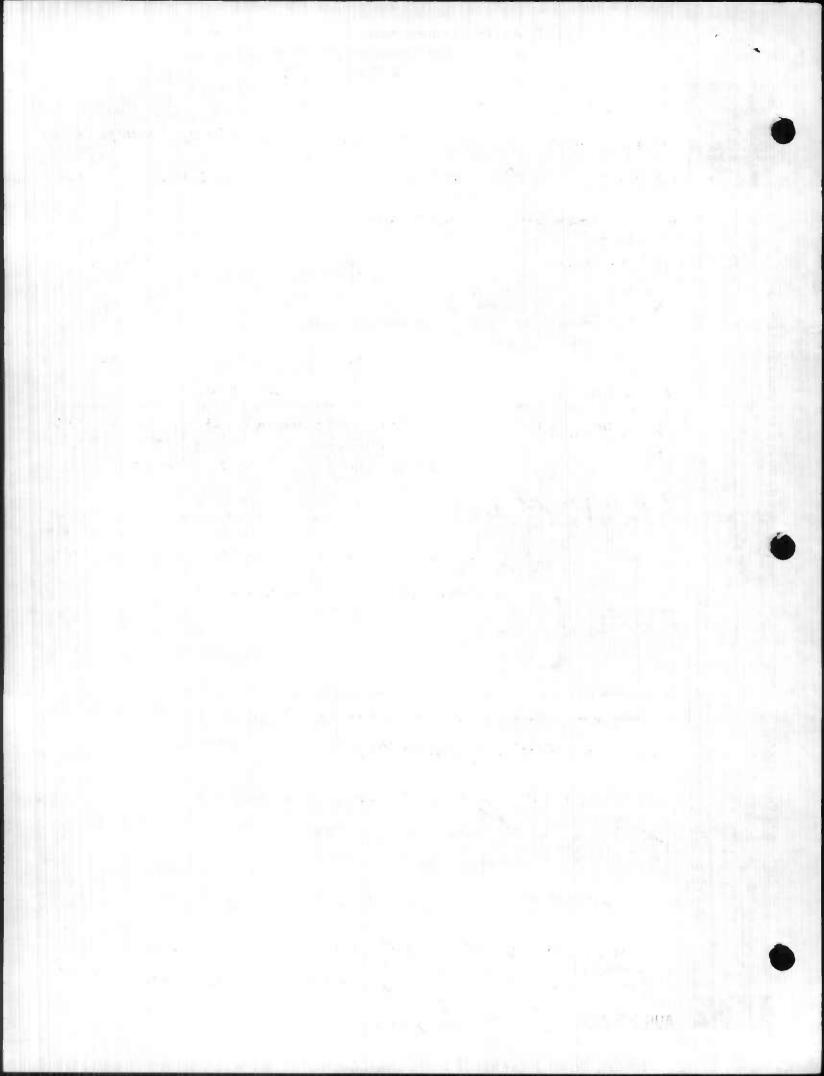
State Registrar 31. Dete tiled (Month, Day, Yaar)

AUG 2 3 2000

mn - 3416 OL AWNWOOD CT #206 OLNOY, mn 20832 DAVID B, HARDING, 32. Ragistrar's Signatura

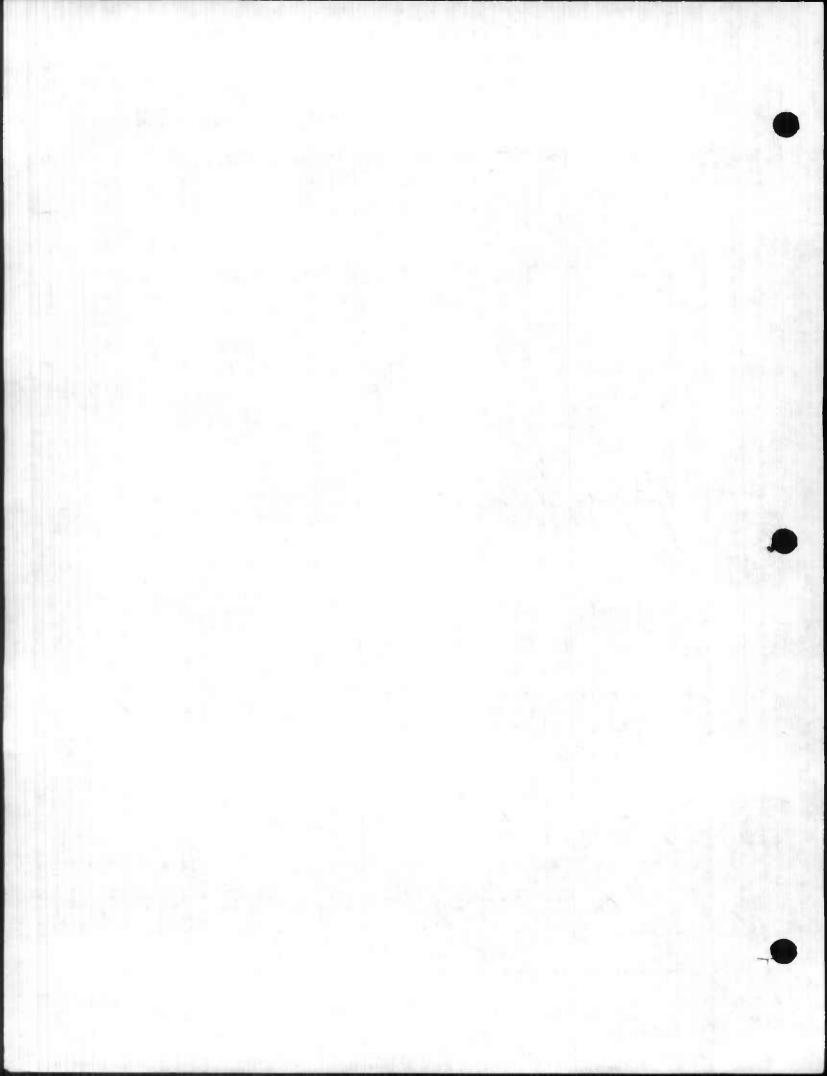
na and addrass of parson who complated causa of death (Ion 23a) (Type, Print)

8/10/00



State of Maryland / Department of Health and Mental Hygiene 00 26668

			Ce	ertificate o	f Death		P	leg. No.		-0000		
Physician /Medical	Decedent's Name (First, Middle, Las	r. Delmer J	ohn Tres	ter			2. Date of Dea Month Au	th Dey g 19, 2000	Year	3. Time of Death 4:15 p.m.		
Examiner	4a Facility Name (If not institution, give	street and number) County General I	Hospital			Colu	cation of Death mbia	4c. County	Hov	vard		
Funeral Director	472-14-5005	7. Age (In	79 Yrs.	Months Day		24 Hrs. Min.	8. Dete of Birth (Month, Dey Jul 23	, Year) , 1921	9. Birthp	place (Stete or Foreign atry) Minn.		
28a-f show notified at rector	Usuel Residence of Decedent 10a. State 10b. County Maryland Hot	ward	c. City, Town or I	Location	Columbia	a			1	0d. Inside City Limits 1 ☐ Yes 2 € No		
0 2 0	10e. Street and Number 10312 Wilde Lake Terr.			10f. Zip Code	210	44	10g. Citizen of What C					
ar, or hame 23d Examiner must by Funeral	11. Marifal Stafus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates:	1943 1946	. Was Decedent of If Yes, specify Cu		gin? (Spe n, Puerto	ecify Yes or No- Rican, efc.)		ck, White,	ean Indian, etc. White		
Medical	15. Decedent's Edi (Specify only highest grad		(Giv	edent's Usual Occ re kind of work don DO NOT use reti	e during mos	t of worki	ing 16b. Kind of Business/Industry Library Of Congre					
Be Completed	17. Father's Name (First, Middle, Last)	7		Ci	vil Servic		(First, Middle,	Maiden Sumen	ne)	Congress		
To	Arthur 19a. Informent's Neme/Relationship (7	Trester ype, Print)		iling Address (Stre			I Route Numbe			Code)		
or other tr	Ms. Linda 20a. Method of Disposition 1 XBuriel 2 Cremation 3	Removal from Stete	20b. Piece of Disposemetery, cr	6801 Kiowa loosition (Name of emetory or other p	/ece)		Date 08/21/00	20c. Location		or Town, State		
9000	4 Donetion 5 Other (Specify 21. Signature of Furtheral Service Licens	-		nd Veterans 22, Name and Add Slack	ress of Facili	y ty Home,				iviai ylallu		
lor use as the bunal-trensit au lie or use as the bunal-trensit bunal lie or use as the bunal-trensit can bunal lie or use as the bunal lie or	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet intileted events resulting in death) Last	b. right to Due tung tu	horacic to (or es a cons horacic to (or as a cons mor to (or as a conse	outlet s	syndron		deep v	ein thu	rombo	Onset and Death		
by Physician		er eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. COMONARY antery disease							23b. Dld tobacco uss contribute to the cause of			
pieted by	hypertension cardiac arrh						24a. Was a perior	an autopsy med?	av	ere autopsy findings alleble prior to impletion of cause death?		
director, page To Be Com	25. Was case referred to medical examiner?	y cimira.			26. Plac	e of Deat	1 🗆 Y		11	☐Yes 2☐No		
unerel	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Dey Ye	2 ER/Dutpati	of 28c. In			me 5 Resid 28d. Describe h			(y)		
completely filled in by the funere Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, s	street, factory, office	ie .		28f. Location (5 City or Tow	itreet and Num n, Stete)	ber or Run	el Route Number,		
pletely fi		sician: To the best of m iner: On the basis of exa and menner stated	amination and/or									
w w	29b. Signature and title of certifier 29d. Date signed (in D31927 august)								4	Dey, Year) 2 , 2000		
(1)	30. Name and address of person who of Feng, Ho-Lai 2 Knoll No.	ompleted cause of (eath orth Drive Colum	i (Item 23a) (Typo ibia, MD, 21	e, Print) 045								
State	31. Date filed (Month, Day, Year) ALIG 2 3 200	32. Abgistrar's	Signature &	Spark	6							



N-J.

DHMH 16 Rsv 6/95

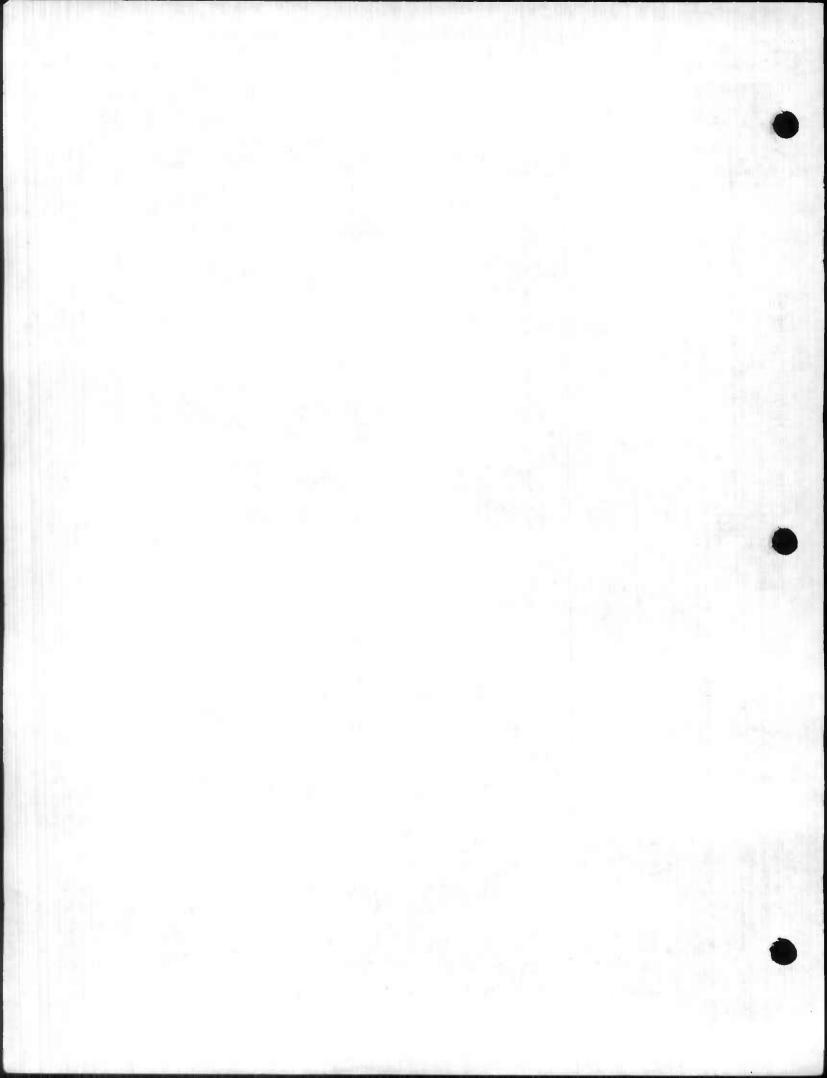
State Registrar 31. Date filed (Month, Day, Year) AUG 2 3 2000

eddress of person who completed cause

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

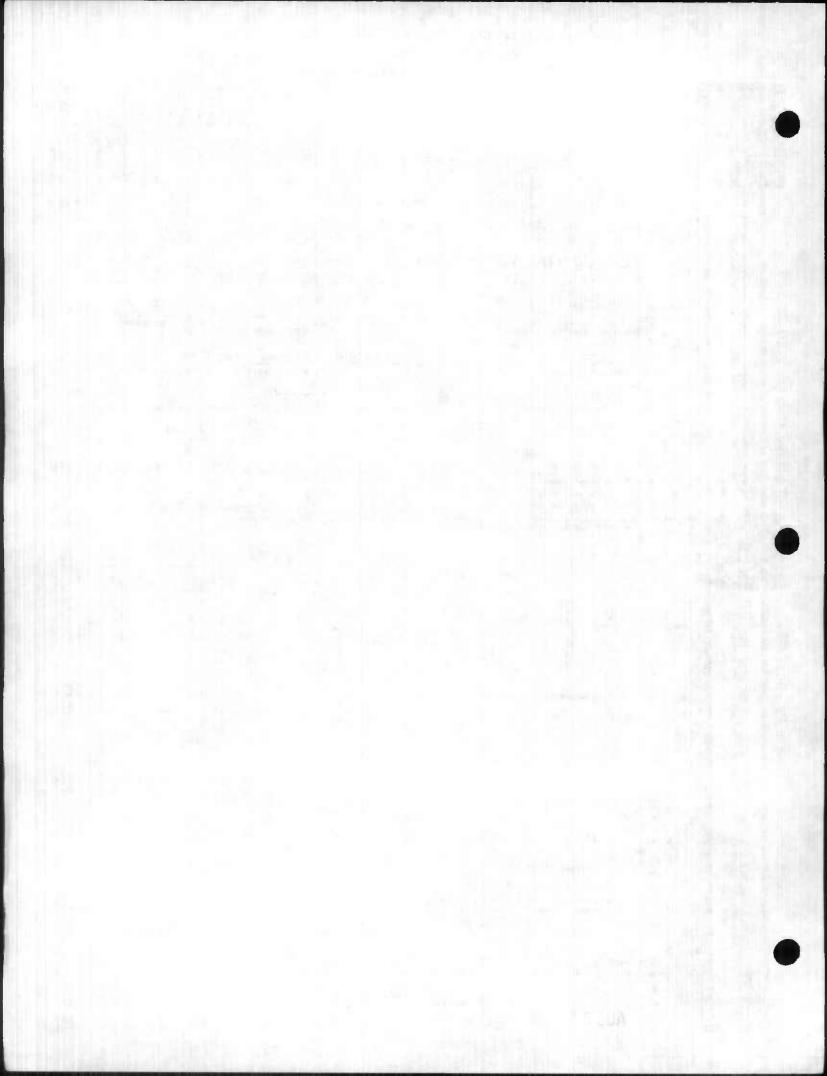
Main (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No	00	26670
	Dt. atatair		2. Date of Death Month Day	Year	3. Time of Death
	Physician /Medical	Catherine Vaughn	lugust 10		4:50pm.
	Examiner	4a Facility Name (If not institution, give street and humber) 4b. City, Town, or Loc	cation of Death 4c.	County of Death	1
		50N SECOURS HOSPITAL BALTI 5 Social Security Number 6 Say 7 Ang In yes last high day 1 ft Under 1 Year 1 ft Under 24 Hrs.		N	A
	Funeral Director	21/ / / Man and 1 M 2M F	8. Date of Birth (Month, Day, Year) OCT, 12, 19		place (Steta or Foreign ntry) RYLAWD
	Pun Man	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Marylar 28a-f ehow notified at	MARYLAND NIA BALTIMORE CITY			1 Yes 2 □ No
	with the Maryland a or 28a-f show the notified at	10e. Street and Number 10f. Zip Code	10g. Cit	zen of What Cou	ntry?
	23a or	4010 WOODMERE AVENUE 21215		USA.	
	- E - E	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Spenting Yes, specify Cuban, Mexican, Puerto Forces)	city Yes or No-	14. Race - Ameri Black, White,	
5-0020	by by	1 Never Married 2 Married I Yes, Give 1 Yes 2 No Specify:	1001, 010.7	Specify: BL	ACK
5-0	72 h	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)	16b. K	nd of Business/In	dustry
2121	bed within 72 ho ygiena. Wr than "naturn nt, me we deal Completed	Elementary/Secondary (0-12) Collega (1-4or 5+)			= 1 /= 0 =
	Hygienu Hygienu Im, me Corr	17. Fether's Name (First, Middle, Last) STEAM PRESS OFERA 18. Mother's Name	(First, Middla, Maidan		EANERS
Maryland	B Sept	JOSEPH LEE CORA	(Tot, Woods, Walles	CMN-UN	
Z	d 2 should the and Men 7 is marke traumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rura)	I Route Number, City of		
M	od 2 signal ar trau	LEROY VAUGHN (SON) 13804 BEECH WOOD FR			
ē,	s 1 and if Haaith Hem 27 other tu	20e. Method of Disposition 20b. Place of Disposition (Nama of	Date 20c. Lo	ocation - City or T	own, State
Baltimore,	Page ent c nt: If ny or	#Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL PARKS	1-24-M WO	ONIAG	IN MA
alti	permit. Pa Departmen Important: any Injury pace.	21. Signature of Furniral Square Licensee 22. Name and Address of Facility JOSEPH H. BROU	INERAL	HOME	
m	Depa impo any l	DOSEPH H. 15kg			
		23a. P. III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or shock, or heart failure. List only one cause on each line.	r respiratory arrest,	ALTITION,	Approximate Intervel Between
	Physician	Show, o Healt lande. Est only one cause of each line.			Onset and Death
-4	/Medical	Immediate Cause (Final disease or condition Sepsis Syndrams			2 wers
	Examiner	Due to (or as a consequence of): Thected Surral decubiti war.	5		2 Weeks.
	executed in and ial-transit Examiner	b. "			
90,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Due to (or es a consequence of):			
68760	ohys the dic	that initiated events			
	2 01	d.			
Box	death certif e attending d for use a				
0	that the death cered by the attending detached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			to the cause of death?
0	ed by detac	Diabetes Mellitus.	1 Yes 2	ENO 3LIPRO	obably 4 Unknown
Division of Vital Records,	The law requires that the death cent sate has been signed by the attending page 2 should be detached for use Completed by Physician/M		24a. Was an auto	psy 24b. V	Vara autopsy findings vailable prior to
00	law req		performed?	0	ompletion of cause f death?
Re	certificate has rector, page 2 be Comp		1 ☐ Yes 2	IDNo 1	☐ Yes 2☐ No
ita	entifical actor, p	25. Was case referred to medical 26. Placa of Death	(Check only ona)		
t <	Physicien: this certific ral director, I: To Be	examiner? 1 Yes 2 No Hospital: 1 Inneatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Rasidance	6 ☐Other (Spec	ify)
0	ng Ph ther th neral	27. Manner of Death 1 Political 5 Pending 28a. Data of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe how Inju	ry occurred	
SIO	ending oath. or: A the fu	2 Accident investigation M 1 Yes 2 No			
Z	frech frech in by rtiffi	3 Suicide 6 Could not be detarmined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street a City or Town, State	nd Number or Rui a)	al Routa Number,
	Ce illed			N 4	
	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral director and the funeral director of the funeral director	29a. Certifiler (Check only one) 1. Certifying Physician: To the best of my knowledga, daath occurred at tha time, date and place, a complete one of the date of			
_	within omple	29b. Signature and title of certifier 29c. License number	29d. Da	te signed (Month	, Day, Year)
	F 3 F 0	Mary Marcal House office DYE148	Tun	IST 19. 7	000
		80 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Lington	111111111111111111111111111111111111111	
)	Kicaido Osorno, MD 2000 West Baltimere STreet, Baltimo	rs, Maylanc	1 2122	3
	State	31 Date filed (Month, Day, Year) 32. Registrar's Signature			
9	Registrar	AUG 2 3 2000 Denera B Sparks			

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

26671

						Ce	runcai	e or	Deam		Reg. No.		-00//	
	Physici /Medic		1. Decedent's Neme (First, Midd Phyllis Mar	ie Warne						2. Dete of D Month Augus	t 22, 2	Year 000	3. Time of Death 12:28 AM	
	Examin	ner	4a Facility Name (If not institution Stella Maris	The state of the s	umber)				46. City, Town, or Li Timonium			of Death	re	
	Funeral Director		5. Social Security Number 218-38-3531	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 58	last birthdey) Yrs.	If Under Months	1 Yeer Days	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, D July 4	irth ay, Year) 1942	9. Birthi Cour Mart	place (State or Foreign play) Yland	
	pu .		Usuat Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cetion						Od. Inside City Limits	
	with the Maryland a or 28a-f ehow	ctor		imore	100.0		Balti	nore	7.5		1 □ Yes 2 汉 N			
	5 2	Oire	10e. Street and Number				10f. Zip				10g. Citizen of			
	23a	e	1 Dalmeny Cou	rt, Apt.	204			212				I.S.A.		
	72 hours effer death natural, or flems 23	by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puèrlo Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No							o- 14. Ra Bla Specii	ck, White,	can Indian, etc. White		
2	Pour Promise	Pe	~	nt's Education	Dailes.	16a. Dece	dent's Usu	al Occur	ation		16b. Kind of B	lusiness/in	dustry	
03000	yithin yiene. r than "	Completed	(Specify only higher Elementery/Secondery (0-12)	st grade completed	(1-4or 5+)	(Give	kind of wo DO NOT u	rk done se retire	during most of work		Publi			
	Wental Hy Mental Hy arked other artic event,	To Be C	17. Father's Name (First, Middle, Victor Moor						18. Mother's Nam		e, Maiden Sumei Oliver	ne)		
	d d d d d d d d d d d d d d d d d d d	'n	19a. Informent's Name/Relation Mrs. Wendy Ph			r) 16	Pine	cone	end Number or Rui			234	Code)	
	Page ent.	ř	20a. Method of Disposition 1 Burial 2 Defending 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Green Mount Crematory 8/23/00 Baltimore											
11100	permit. Page Department of Important: If eny Injury or		21. Signature of Funeral Service	Licensee	0012	22	Schu	nune	ss of Facility k Funeral air Rd.,	Home,	Inc.	212.	3.6	
	Physician /Medical Examiner	er.	23a. Pert1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)		UNG CAN			le of dyir	ng, such es cerdiac	or respiratory	errest,	1	Approximate Interval Between Onset and Death	
03203		n/Medical Examiner	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that infleted events resulting in death) Last	6 c		or as a consec or as a consec								
0		Physician	Part It. Other eignificant conditi	one contributing fo	death but not res	sulting In the u	nderlying (ause oi	en in Part I.	23b. Die	d tobacco use co	ontribute 1	to the cause of deat	
0	of the	hy								10	Yee 2□ No	3 □ Pro	bably 4X Unkno	
_	ne lew requires the has been signed ige 2 should be del	Completed by F								24a. Wa	s an autopsy formed?	81	/ere autopsy findings vallable prior to empletion of cause	
000	has b	igh.			9.06.	1 500						of	deeth?	
		S							423	10	Yes 2X No	1	☐ Yes 2☐ No	
	Vician: The	Be	25. Was cese referred to medical examiner?					011	26. Place of Dee	th (Check only	one)			
Losivies of Vital	Alfing Phys h. After this funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pendi 2 Accident Invest	28a. Det	Inpatient 2 C e of Injury onth, Day Year)	28b. Time o		28c. Injui Wo	4 LI Nursing Ho		sidence 6 X Ot s how injury occu		(y) HOSPIC	
Olivio	To the Hospital or Attendi thin 24 hours after death To the Funeral actorics a completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could	nined 289. Plet	ce of Injury - At h Iding, etc. (Special	ome, farm, st	reet, factor	y, office			(Street and Num own, State)	ber or Rui	al Route Number,	
	the Hospital hin 24 hours the Funeral npletely filled	edical		ng Physician: To the Examiner: On the and ma										
	To the Com	Σ	29b. Signature end title of certific	er)			29	0	se number		29d. Dafe sign	ed (Month	Dey, Year)	
	0.0			1000				Dr	17725		8/	22/1		
	3		30. Name and address of person DR. TARIO M.		use of death (Iter			RD.	TIMONIU	M, MD	21093	10		
1	Sta Registr		31. Date filed (Month, Dey, Year, AUG 2 3 20	32.	Registrar's Sign		loon	K						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month WHITEN IGUS 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8. Date of Birth Month, Day, Yeer) BALTIMORE VOTERANS ADMINISTRATION BALTIMO or Hunder 24 Hrs. Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) If Under 1 Ye Months Hours MM 2DF 73 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA BALTIMORE 1 X Yas 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 USA 2803 EDGECOMB CIRCLE NORTH 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian Black, White, atc. 1 ☐ Yes 2 ☐ No 7—1952 If Yes, Giva Year or Dates: 10—1957 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) NA Elementary/Secondary (0-12) STEEL WORKER BETH. STEEL 6th 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) FATE WHITEN CELIA SMITH 19e. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA WHITEN-DAUGHTER 320 MELVIN AVE. CATONSVILLE, MD 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data XIXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW HOPE CEMETERY 8/19/00 BLAIRSTOWN, L.A. re of Funeral Service Licen 22. Nama and Address of Facility MARCH FUNERAL HOME WEST, INC ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, no cause on each line. 21215 23a. Parti. Enter the dis-shock, or hear falls Approximete Interval Batween Onsat and Death Immediata Causa (Final PNEMMONIA diseasa or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No END STAGE PENAL DISEASE 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes casa rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 Denpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

ith and Mentel Hygiene. 27 is merked other than "r r traumetic event, me the

. Pages 1 end 2 should be fill ment of Health end Mentel Hant: If item 27 is marked oth jury or other traumatic even

Department or Important: If any Injury or page.

Director

Funeral

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Completed

8

21. Silk

the Manyland

filed within 72 hours efter

21215-0020

Baltimore, Maryland

Examiner Physician/Medical A Completed Be

burial-transit pue physicien the burie signed by the attending p page 2 certificate funeral director. Medical Certification: To sins After the

The law requires that the death certificate be asscuted Box 68760, P.0. Division of Vital Records, or Attending Physician: 24 hours after death. Funeral Director: Al filled in by Hospital

completely within 2.

State Registrar

27. Manner of Death

1 Matural

3 ☐ Suicide

29a. Certifier

2 ☐ Accident

4 Homicide

(Check only one)

29b. Signature and titla of confie

BESIDENT PHYSICIAN

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Data signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore Veterans Administation G. Carangal,

28b. Tima of

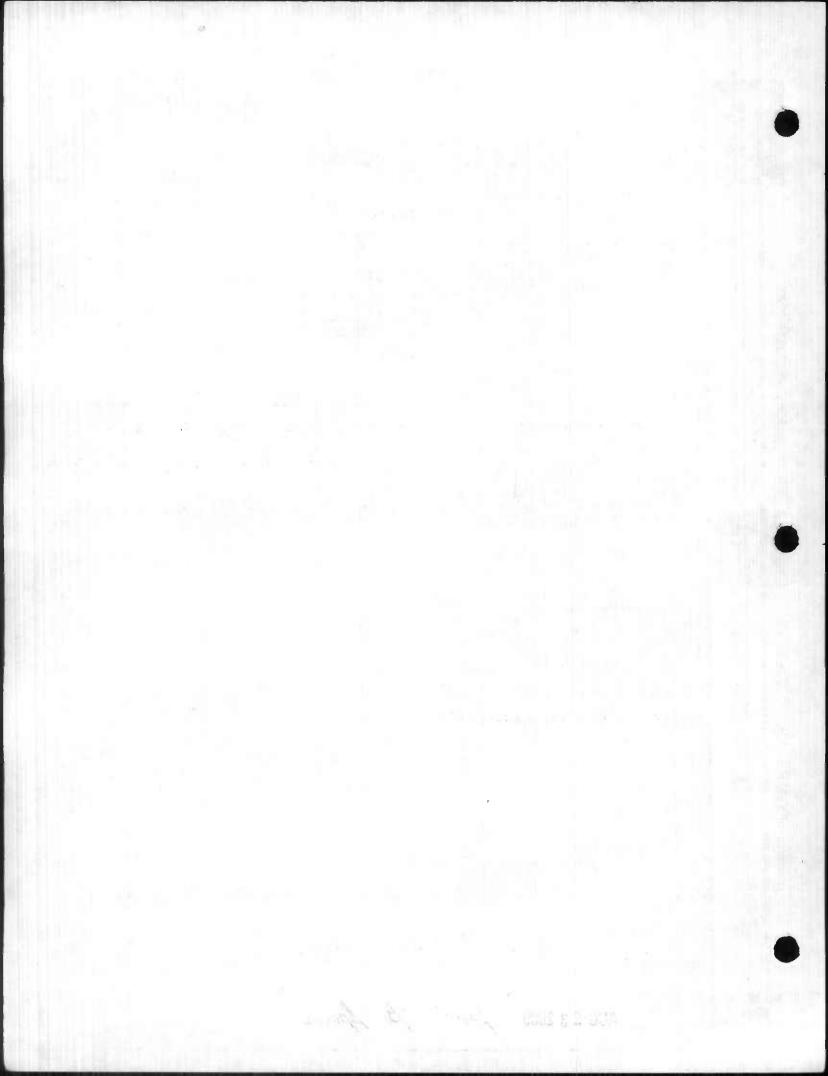
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

31. Data filed (Month, Day, Year)

5 ☐ Pending invastigation

6 ☐ Could not be determined

32. Registrar's Signature AUG 23 2000



00-4758-510

WASHINGTON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

	ricase Type of Fillit in Diack indelibit
LARRY	State of Maryland / Departmen

t of Health and Mental Hygiene

2667

Physician	
/Medical	
Examiner	

LARRY ANDREW WASHINGTON 4a Facility Name (If not Institution, give street and number)

2. Data of Death

3. Time of Death Day **AUGUST** 21,2000 7:22P.M. 4c. County of Death

Funeral

SHOCK TRAUMA CENTER 5. Social Security Number 213-92-4784

10b. County

1. Decedent's Nama (First, Middle, Last)

1 □M 2 □ F

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days 30 Yrs.

6. Date of Birth (Month, Day, Year) 08-28-69 Hours

4b. City, Town, or Location of Death

BALTIMORE

9. Birthplace (State or Foreign MARYLAND

Director

or 28a-f show

the Medical Examiner must be notified at

"naturel", or items 23a

than

Pages 1 and 2 should be fill ment of Health and Mental Hant If Hem 27 is marked off

Department of Important: If any Injury or and Injury or an

Examiner

attending physician for use as the burie

certificate has been signed by the a irector, page 2 should be detached.

this

After

after deeth.

I Director: Af
od in by the fu

within 24 hours a To the Funeral C

To the

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

filed within 72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

þ

Completed

10a. State MD 10e. Street and Number 10c. City, Town or Location BALTIMORE MARYLAND

10f. Zip Code 10g. Citizen of What Country?

1 XYes 2 No

10d. Insida City Limits

602 BRAESIDE ROAD

Usuel Residence of Decedent

11. Marital Status 1 □ Nevar Married 2 □ Married 3 ☐ Widowed 4 🕅 Divorced

12. Was Decedent Ever in U,S. Armed Forcas? 1 X Yes 2 ☐ No If Yes, Give

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☐X0o Specify:

14. Race - American Indian, Black, White, etc.

BLACK

21207

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CORRECTIONAL OFFICER

21229

16h Kind of Business/Industry CORRECTIONS

U.S.A.

12

17. Father's Nama (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumeme)

Date

BURNEDETTE V. EDMONDS

LARRY WASHINGTON

19e. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

5939 TALBOTT ST, BALTIMORE, MD

BURNEDETTE WASHINGTON 20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, crematory or other place) 1 Surial 2 Crem 3 □Rem King Memorial Park 4 Donation 5 Other (Specify)

8-25-00 RANDALLSTOWN,

20c. Location - City or Town, State

21. Signaturajol Farieral Socios License

22. Nama and Address of Facility HOWELL FUNERAL HOME

4600 LIBERTY HGHTS AVE, BALTO. MD 21207 Approximete Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical

Examine

Physician/Medical

þ

Completed

Be

10

Certification:

Medical

Immediata Cause (Final disease or condition resulting in death)

· Multiple injuries with complications Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Inspection 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case reterred to medical examinar? 1 Yes 2 No

27. Menner of Deeth

5 Pending invastigation 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospitel: Compatiant 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Dete of Injury (Month, Day Year) 8-20-2000 0005

Street

28c. Injury at Work?

1 Yas 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred operator of motorcycle involved

in a collision 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3600 New York Ave, NE washington, D. C.

29a, Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner es stated.

Medical Examiner: On the best of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and litle of certifiar 29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) AUGUST 22,2000

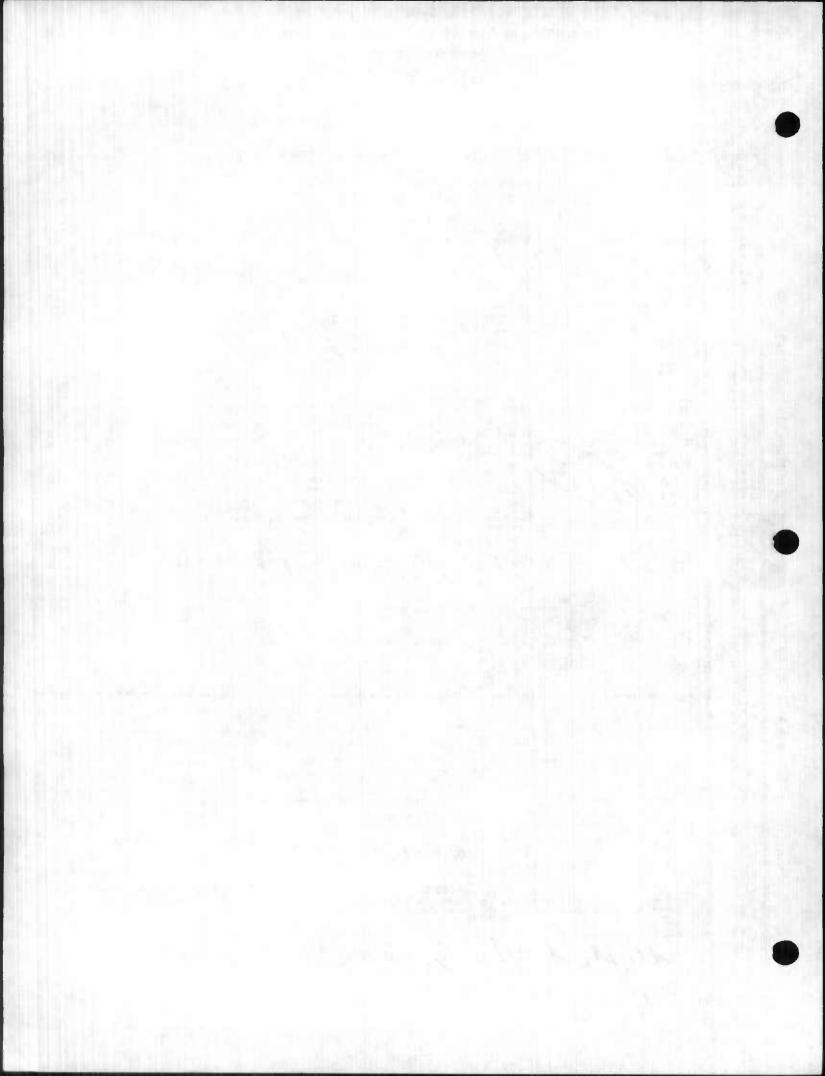
30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

5, onen 31. Date filed

Radentz 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

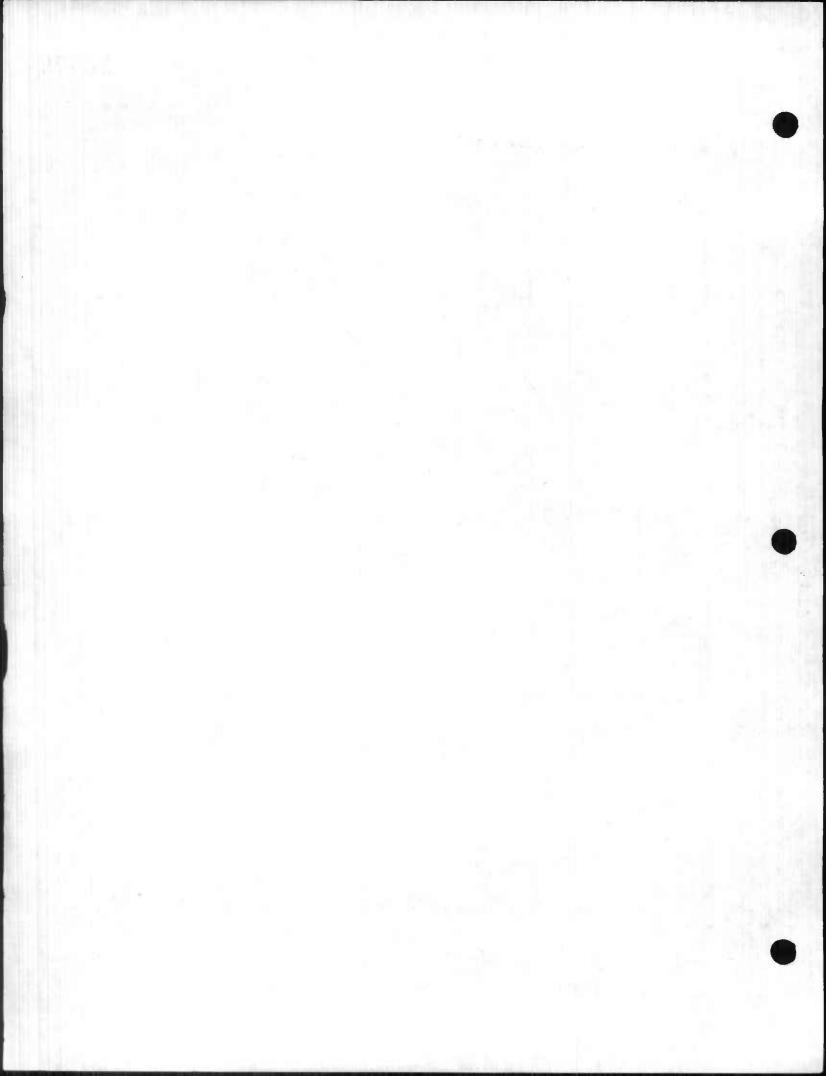
State Registrar



State of Maryland / D

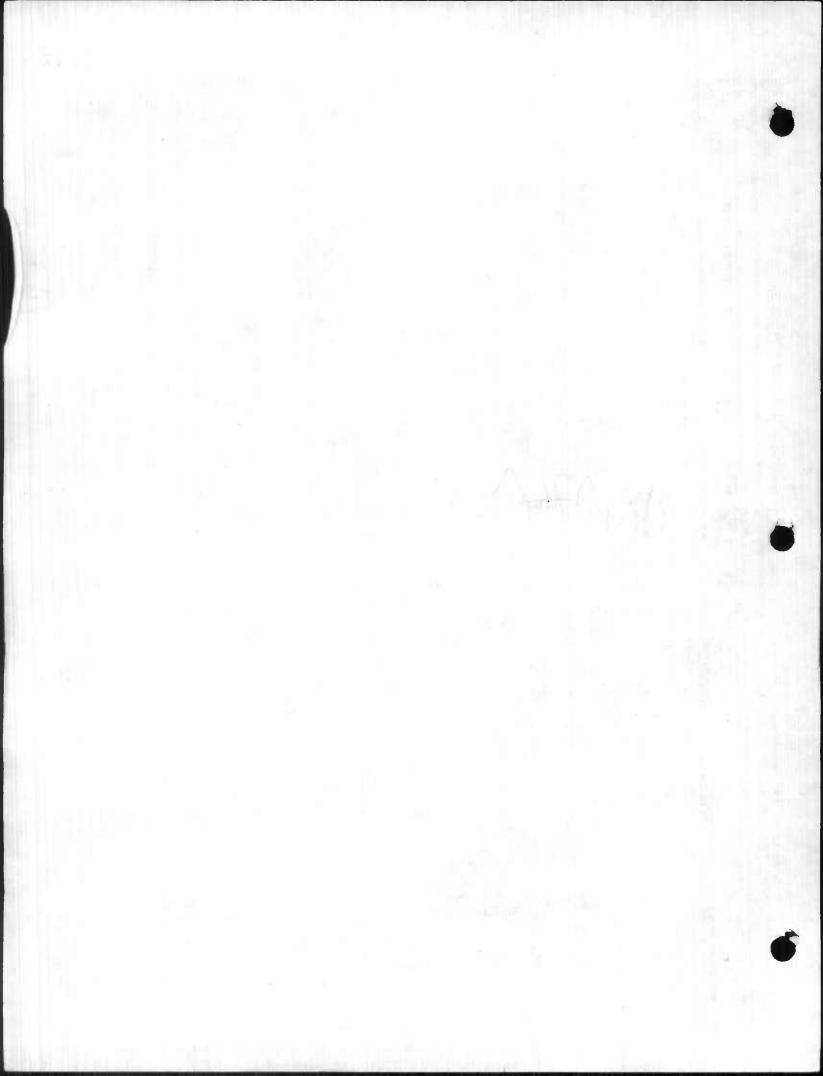
Department	of	Health	and	Mental	Hygiene	
Cortificate	of	Dogt	-			

		Certificate of	Death	R	eg. No. UL	266/4					
						3. Time of Death Year					
Reynaldo Alv	varado			August	05 20	00 05:20 P.M.					
4a Facility Name (If not institution, give	re street and number)		4b. City, Town, or L	ocation of Death	4c. County of	of Death					
	**					e George's					
none	Sex 7. Age (In yrs. las 23			8. Date of Birth	7,4976	9. Birthplace (State or Foreign ETITS alvador					
10a. State 10b. County						10d. fnslde City Limits 1 Yes 2 □ No					
	deorge 5 ii										
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	venue #201		33		10g. Citizen of What Country? El Salvador						
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:				Black	- American Indian, s, White, etc. Hispanic					
15. Decedent's E		16a. Decedent's Usual Occi (Give kind of work don	upetion e during most of work	king	16b. Kind of Bus	siness/Industry					
Elementary/Secondary (0-12)	College (1-4or 5+)										
17. Father's Name (First, Middle, Last			18. Mother's Neme (First, Middle, Maiden Sumame) Elijia Bonilla								
19a. (nforment's Name/Relationship (Type, Print) Alba Alvarado/Sister Alba Alvarado/Sister 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, 8240 14th Avenue#201 Hyattsville											
20a. Method of Disposition 1 □ Burial 2 □ Cremation 3X	20b. Plac cerr Removal from State Conc	Date	20c Location - C	City or Town, State Cion de Orier Vador							
	Ti.	22. Name and Add	ress of Facility D.RINALD EW Hamps			1					
23a. Part1. Enter the disease, or com	plications that caused the death.					Approximate Interval Between					
						Onset and Death					
Immediate Cause (Final disease or condition	SEIZURE D	ISORDER									
Toodking in dealing	Due to (or a	s s consequence of):									
Sequentially list conditions,	b Due to (or a	s a consequence of):									
Cause (Disease or Injury that initiated events											
d.											
Part fl. Other significant conditions of	contributing to death but not resulti	23b. Did tobacco use contribute to the cause of death									
		1 Yes 2 No 3 Probably									
						24b. Were autopsy findings available prior to completion of cause of death?					
				1 🛚 Y	es 2 No	X Yes 2□ No					
25. Was case referred to medical			26. Place of Dee	th (Check only or	ne)						
exeminer? 1X Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 Resid	ence 6 Othe	or (Specify) Scene					
27. Menner of Death 1 Alatural 5 Pending 2 Accident Investigation	(Month, Day Year)			28d. Describe h	ow injury occurre	ed					
		e, farm, street, factory, offic	8	28f. Location (S City or Tow	treet end Numbe n, Stete)	er or Rural Route Number,					
29b. Signature and title of certifier		29c. Lice	nse number	2	29d. Date aigned	(Month, Day, Year)					
IN	VIII		O.C.M.E.		Augu	st 6, 2000					
7//	1 66										
30. Name and address of person who JOSEPH PESTANER		3e) (Type, Print) 111 Penn St	reet, Balt	imore. M	aryland						
	Reynaldo Alv 4a Facility Name (If not institution, gives 240 5. Social Security Number 6. Security Number 10a. State 10b. County Md 10b. County Md 10b. County Md 11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Expective only highest grace Elementary/Secondary (0-12) 3 17. Father's Name (First, Middle, Last Lazaro Alvara 19a. Informent's Name/Relationship (Alba Alvarado/Secondary 10b. Signature of Funeral Serve Unit 10b. Signature of Funeral Serve Unit 10b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or condition resulting in death) Part fl. Other significant conditions of the county in the county	Seculity Name (If not institution, give street and number) 8240 14th Avenue #2	1. Decedent's Name (First, Middle, Last) Reynaldo Alvarado 4a Facility Name (If not institution, pive street and number) 8240 14th Avenue #201 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 year 2 year 1 year 2 year 1 year	Reynaldo Alvarado 4s Feolity Name (finor institution, give street and number) 8240 14th Avenue #201 Hyattsv	2. Date of the Name (Frist, Middle, Let) 2. Date of the August 45. Cely, Town or Location 45. Cely, Town or Location 45. Cely Town o	Decedere Name (Pirst, Medical, Late) Reynaldo Al varado 20					



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

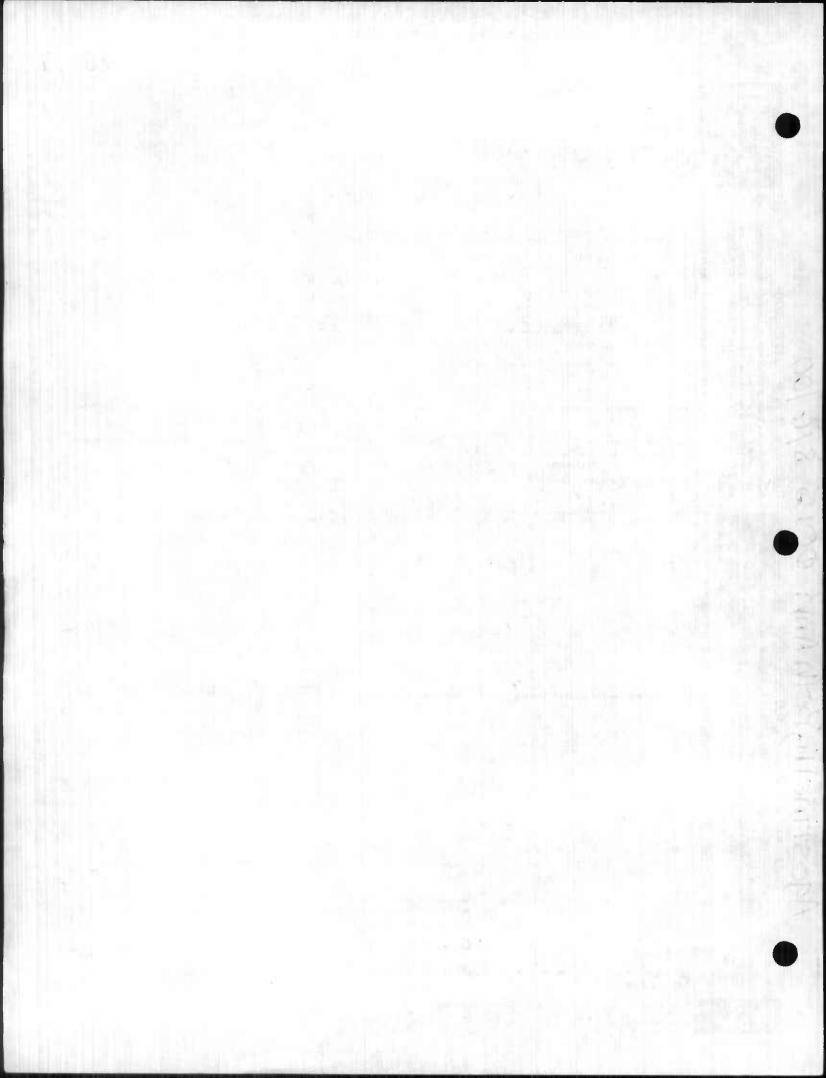
					ı ıvıaı yıaı	Cei	rtifica	te of	Death		Reg. No.	0 2	6675	
	Physician	Decedent's Nama (First								2. Data of Do Month	Day	Year	3. Time of Death	
	/Medical	Bhagwandas	Adv	vani						August	-		3:05 PM	
- }	Examiner	4a Facility Nama (If not in	0.0	U.S.	nber)				4b. City, Town, or	Location of Deal	h 4c. Count	y of Death		
		Holy Cross							Silver S	-		tgomer	-	
ı	Funeral Director	5. Sociel Security Number N/A		ex ⊠M 2□F	7. Age (In yrs 96	. last birthday) Yrs.	Months Months	Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D) July 26	nth ay, Year) 1904	9. Birthple Counti Karach	oce (State or Foreign) British I, India	1
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Maryland 21215-0020	or he	1 Nevar Married 2		Armed For 1 Yes If Yes, Giv Yeer or De	rces? 2 🔯 No e		f Yes, spe 1 ☐ Yes		tispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)	Bla Specil	ck, White, e		
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215	ed within 72 horygiene. Art then "natural, the Modern Completed	(Specify only Elementery/Secondery		de completed) College (1	-dor 54)	(Give	kind of wo	ork done ise retire	pation during most of wo d)	rking				
21	r the	-	0-12)	4	-401 54)	Elect	rical	Eng	ineer		Electi	ric Co	mpany	
P	al Hy d other	17. Fether's Name (First, I	Middla, Last)			3.4			18. Mother's Ner	ne (First, Middle	, Maiden Surna	ne)		
1	Menta Menta mrked arice	Himmatsingh	Advan	ni					Ishwari	. (Not Ava:	ilable)	
an	and in me	19e. Informent's Neme/Re	lationship (7	Type, Print)	10.00	19b. Meilir	ng Addres	s (Street	and Number or Ri	iral Route Numb	er, City or Town	, Stete, Zip (Code)	
2	and 2 27 i	Nalini Wadhw	ani/Da	ughter		1640	4 Equ	estr	ian Lane	, Rockv	ille, Ma	arylan	d 20855	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; any Injury or other traumatic event, the Medical Engage.	20a. Method of Disposition 1 Burial 2 Cran 4 Donetion 5 D	nation 3 🗆		Siele	Plece of Dispo cemetery, crea	matory or	other pla		August	20c. Location Bethesda			
Balti	permit. Departminports any Inju	21. Signature of Funerel S	y cros trour	1 / \	0 0689	. 22	2. Name e	nd Addre	ess of FacilityRob hevy Cha	ert A. se, Inc.	Pumphrey 7557 W	y Fune	ral Home, sin Avenu	/ ie
	Dhurisian .	23a. Part Librardhe bile thook of heart failur	ese, or comp e. List only o	14		th. Do not ent	er the mo	Bethe de of dyir	esda, Mar ng, such as cardia	yland 2 or respiretory	0814-35(irrest,		Approximate Interval Between Onset end Death	
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting In death)		Acute	Pulmo	nary E	dema						24 hrs	
L	sit and			Acute		or as a consecutive as			ction				24 hrs	
,00	ficate be axecuted physicien end is the burial-transit	Sequentielly list conditions if eny, leeding to immedie cause. Enter Underlying Cause (Diseese or Injury		Coror		or as e consectery D								
x 68760,		thet initialed events resulting in deeth) Lest	l	d	Due to (or es a conseq	juence of):							
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0	the de sched sched	Pert II. Other algorificant c	onditiona co	ontributing to de	ath but not re	sulting in the u	nderlying	cause giv	ven in Pert I.				the cause of death	17
٩	5 00 >	Cerebrovas	cular	Accider	nt					1	Yes 2□ No	3 Prob	ebly 4⊠ Unknow	ATI
Records,	The law requiras ate has been sign page 2 should be										s an autopsy ormed?	CONT	re autopsy findings ilable prior to apletion of cause leath?	
- B	The i									10	Yes 2⊠No	10	Yes 2 No	
Vital	ysician: The secretificate director, page Co	25. Wes casa raferred to rexaminer?	nedical						26. Place of De	eth (Check only	one)			
of	2 5 5	1 ☐ Yes 2 ☒ No		Hospitel: 1図II	npatient 2	ER/Outpatier	nt 3□ D	OA Oth	ner: 4 Nursing h	lome 5 ☐ Res	idence 6 □Ot	her (Specify,)	
n	After th funeral tion:	27. Menner of Deeth	Pending	28e. Dete o	of Injury h, Day Year)	28b. Tima of Injury		28c. Injur Wor	rk?	28d. Describe	how injury occu	rred		
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Division		3 Suicide 6 4 Homicide	Could not be determined	28e. Plece buildin	of Injury - At h ng, etc. (Speci	nome, ferm, str ify)	eet, factor	y, office			(Street and Num wn, State)	ber or Rural	Route Number,	
	Hospi 4 hou Funer tely fill			Iner: On the ba					me, date and place opinion, death occu					
	within 24 To the Fu complete	29b. Signetura and title of	certifier		1	1			se number		29d. Date signe			
	11.	1 D55213							.3		August	3, 20	00	
	4	30. Name and address of p	erson who c	completed cause	of death (Its	m 23a) (Type.	Print)							
		Yung Soo Pan	(17			Sil	ver Spri	ng, Mar	yland 20	0902		
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	Registrar	AUG	0 7 20	nn A	come	19	10	- 1						



			State of Ma	ryland		nent of Ficate of		and M	ental Hy	giene Reg. No.	0 2	66	76	
		1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath		3. Time o		
	Physician	Selome Afework						-	Month	Day 10, 20	Year	6:40	am	
	/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)				4b. City, To		ation of Deat			0.10	Citi	
		Holy Cross Hospit	al			The la	Silve	r Spr	ing	Montg	omery			
	[†] Funeral	5. Social Security Number 6. S	Sex 7. Age	(In yrs. las	Mo	Under 1 Year onths Days			8. Date of Bir (Month, De			ace (Stete	or Foreign	
	Director	N/A Usual Residence of Decedent	DIW ZVALE	41	Yrs.			Oct 12, 1958 Ethiopia						
	5 tu	10a. State 10b. County		10c. City, T	Town or Location	n	1 10				10	d. Inside (City Limits	
	Many Hebs	Maryland Montgome	1237	C 1 1 177	er Spri	na			1 ☐ Yes 2					
	or 28s-fr be notifie Directo	10e. Street and Number	Ly	DILV		Of. Zip Code	479			10g. Citizen of	What Count	ry?		
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	shar death w or harms 23a iminer must.) / Furneral	11. Marital Slatus	12. Was Decedent E Armed Forces?		13. Was	Decedent of H	lispanic Ori	gin? (Spec	cify Yes or No	- 14. Rac	ca - America			
2	F. Bank	1 Never Married 2 Married	1 ☐ Yes 2 ☒ N	lo		res 2X No			,	Specif	40			
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175	the Man	Elementary/Secondery (0-12)	College (1-4or 5		Never W		٥,			N/A				
	田工製造 白	17. Father's Name (First, Middle, Last)			MEAST M	OIREG	18. Mothe	r's Name	(First, Middle	, Meiden Sumer	ne)	11		
ılar	Mental be Mental wheel of the ev	Aboye Afework					Getenesh Habtemariam							
Maryland	2 sho and h is me	19a. Informant's Name/Relationship (Type, Print)		19b. Meiling Ad	ddress (Street				er, City or Town		Code)	002	
OE0	Health (Health 27)	Yohannes Afework	/ Brother		1131 U	nivers	ity B	lvd.,	20902 vd., W, #308, Silver Spring, MD					
ore	2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X	Removal from State	20b. Plac	e of Disposition etery, cremeto	n (Neme of			Dete	20c. Location	- City or Tov	wn, State		
Ē	The same	4 ☐ Donetion 5 ☐ Other (Specif		Eth:	iopia			8	/12/00	Ethiop	ia			
Baltimore,	my in	21. Signature of Funeral Service Licer	1500 */	1-		me and Addre		*	Funoro	1 Home,	Tno			
	dozeo	23a. Part1. Enter the disease, or com shock, or heart failure. List only	TM=Mill	lan	500	Univa	reits	Rland	T.T	C41 ****	Spring	Approxima	20901	
Box 68760,	ires that the death certificate be axecuted signed by the attending physician and defached for use as the burial-transit dby Physician/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Chronic c. Diabetes	Renal Due to (or each Nell:	Failur	e of):	ditis							
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P.0.	the d	Part II. Other significant conditions of	ng in the under	lying cause giv	ven in Part I			tobacco use contribute to the cause of death? Yes 2⊠No 3□ Probably 4□ Unknow						
	igned be deta									705 225110	001100	ably 4		
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/Ita	ettor,	25. Was case referred to medical axaminer?						ot Death	(Check only	one)				
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Division of Vitai	ing P where uners	27. Manner of Death 1 X Netural 5 ☐ Pending	28a. Date of Injur (Month, Dey	Year) 28	Bb. Time of Injury	28c. Injui			8d. Describe	how injury occu	rred			
Sio	Attending r death. ector: Afte by the fune ification	2 Accident investigation 3 Suicide 6 Could not b					Yes 2		8f. Location	Street end Num	has as Dusa	l Davita Alice	mbar	
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	To the Nospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 12 Certifying Ph (Check only one) 2 Medicat Exam	d piece, e	nd due to the	ceuse(s) and m date and place,	enner as st	ated. the cause	(s)						
	Me the	29b. Signature and tilled if confiner	and manner sta			29c. Licens	se number			29d. Date sign	ed (Month, I	Dey, Year)		
	FSFO	× 16-6	-			019891 8/10/2000								
4		30. Name and address of person who	completed cause of de	eth (Item 23	3a) (Type, Print		, 0 /	/		7,	/			
		Abraham Dabela, M					rda1e	MD	20737					
	State	31. Date filed (Month, Dey, Year)	32. Registra	r's Signature	e L	Spark	/							
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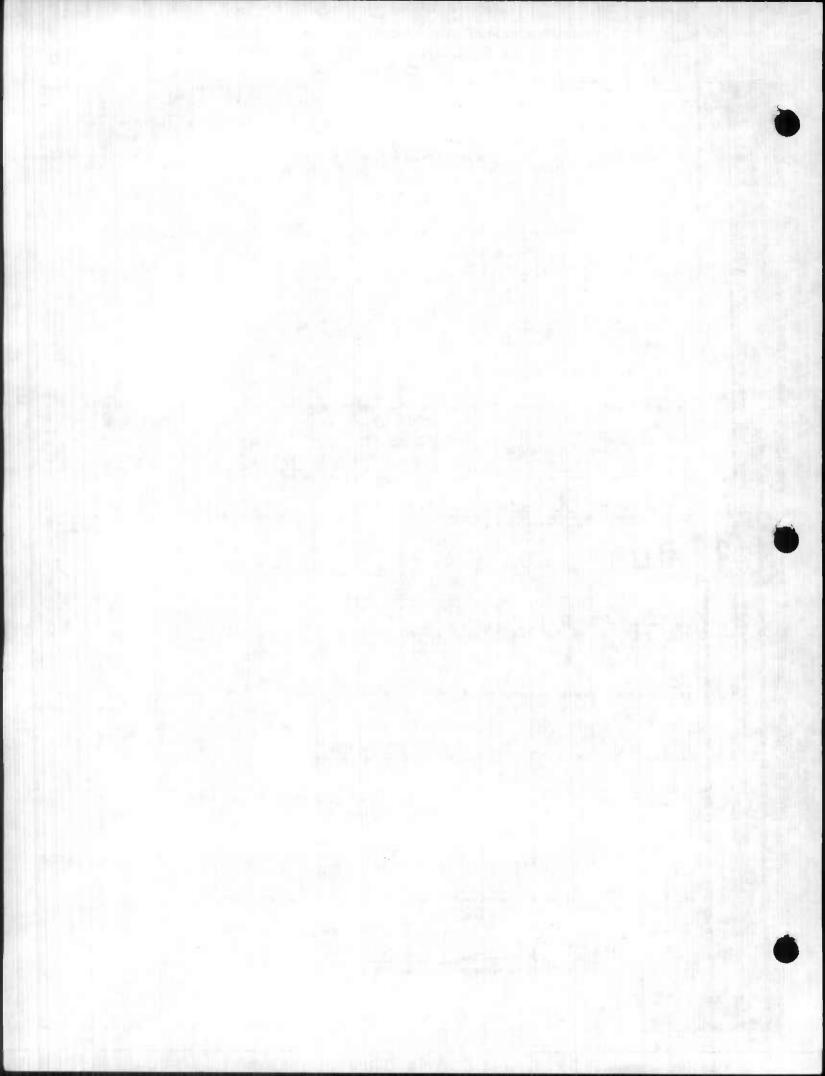
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	Physicia /Medica	n	ELIZABETH ANN AGÓSTINELLI							Date of Death Year August 6, 2000 3. Time of Deet 12:15 A						
	Examine		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location								ation of Death 4c. County of Death					
Coll			Suburban Hospital Bethesda Montgom								<u> </u>					
	Funeral Director		577-30-10	1004	9X □ M 2∏ F	7. Age (In yrs. 7 4		Months	Deys	If Under: Hours	Min.	June l	8, 1926	9. Birthple Countr Wash	ce (Stat y) iing	ton, DC
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21215-0020	the Maryla. 28a-f ahov	5											es 2 No			
	the Mi	ect	10e, Sfreef and Number 10f. Zip Code									10g. Citizen of	What Countr	v?		
	with pe or	5	1801 Kearney Street, N.E.					20018					USA			
	death with the Maryland ma 23a or 28a-f ahow Fress be notified at	Funeral Director	11. Merital Stefus	12. Wes Dece	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Yeer or Detes:		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert			gin? (Spec	ity Yes or No		14. Reca - American Indian,			
	the the	by Fun	1 Never Married	Armed For 1 Tes If Yes, Give			If Yes, specify Cuban, Mexican, Puerto				can, etc.)	Specia	city: Caucasian			
Ö	2 hou			5. Decedent's Ed	ucation	tion		16a. Decedent's Usuel Occupation					16b. Kind of Bus			
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22	D Pa	S L	12	o.y (o .z,	- Comogo (1				Hous	ewife		Home				
N P	be filled tite! Hygid d other event, n	Be	17. Father's Name (Fi	rst, Middle, Last)						18. Mothe	r's Neme ((First, Middle, Maiden Surname)				
Ja S	Mentel Mentel mrked o	9	Ralph Co	zzens					17.	Eloi	is Jea	an Brett				
(6 /0(Maryland	end 2 should saith and Men n 27 le marke er traumatic		19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, S 1801 Kearney St., NE Washington, DC 2													
re,	一工事を	1	20a. Method of Dispos	sition		20b. I	Place of Disp cemetery, cri	position (Na	ame of	ce)		Date	20c. Location	- City or Tov	m, State	
∞ 8	2 = 2		1 ☐ Burial 2 ☐ 0 4 ☐ Donation 5			state	ard U				18	/8/00	Washi	ngton,	DC	
Baltimor	F & 3		21. Signature of Fund			2.0 11									DO	
In a	Departi Departi Importi eny Inf		21. Signature of Fubrial Service Licentees 22. Name and Address of Fecility Lincoln & Lincoln Funeral Service 4315 Anacostia Av., NE Washington, DC 20019													
7		-	23a Part Fotor the	CVI	etions that or	aused the desi	th. Do not er		_					-		
0	Physician /Medical Examiner		23a Part Enter the disease, or domptoetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death													
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0			disease or condition resulting in death)		a. **/V	EUMO									+ DA	15
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= :	and in and	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									u				^
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1 89			resulting in death) Last													
SX	eth certif ettending for use a	3	d													
大田	d lor	Physician/Me	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco use contribute to the cause of death?					
200	es that the igned by th	hys	Pert II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Un					
刀。		by P									12.13					
- Sp											24a. Was an autopsy performed? 24b. Wera autopsy fir evaileble prior to					
- 8	w requir been s should	Completed								portormou		con		of cause		
Re	The lew ate has t page 2 s	E										1 🗆	Yes 2 No	10	Yes 2	2.5 No
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7 2		ToB	examiner?		Hospital: 1 15th	npatient 2	ER/Outpatie	ient 3D C	OA Ot	hor				her (Specify)	
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Son	th.	를	1 ⊠ Natural 2 ☐ Accident	5 Panding investigation		n, Day Year)	Injury	м		Yes 2	No					
/isi	Attending or death.	100	3 Suicide	6 Could not be determined	200. Placa	of Injury - At h	nome, farm, s	street, fecto	ry, office	6	21		(Street and Num	ber or Rural	Route N	vum <i>ber</i> ,
砂点	after d Direct d in by	er	4 Homicide		buildir	ng, etc. (Speci	ity)					City or 10	wn, State)			
7	Hospital 24 hours a Funeral Lielely filled	edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.													
	To the Hos within 24 h To the Fur completely		29b. Signature end title of certifier 29c. License number 29d. Date sign									ed (Month, L	Day, Yea	(r)		
			D. Virramadilya Meddy no D43464								AUGUST - C6 - 2000					
	10	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										, -			
			30. Name and addres						re, s	UZAE 2	108, 1	LOCKUS	rue, M	2088	2	
	Stat Registra	е	31. Date filed (Month,	G 1 0 20	32. R	egistrar's Sign		de	ock	2						



State of Maryland / Department of Health and Mental Hygiene 00 26678

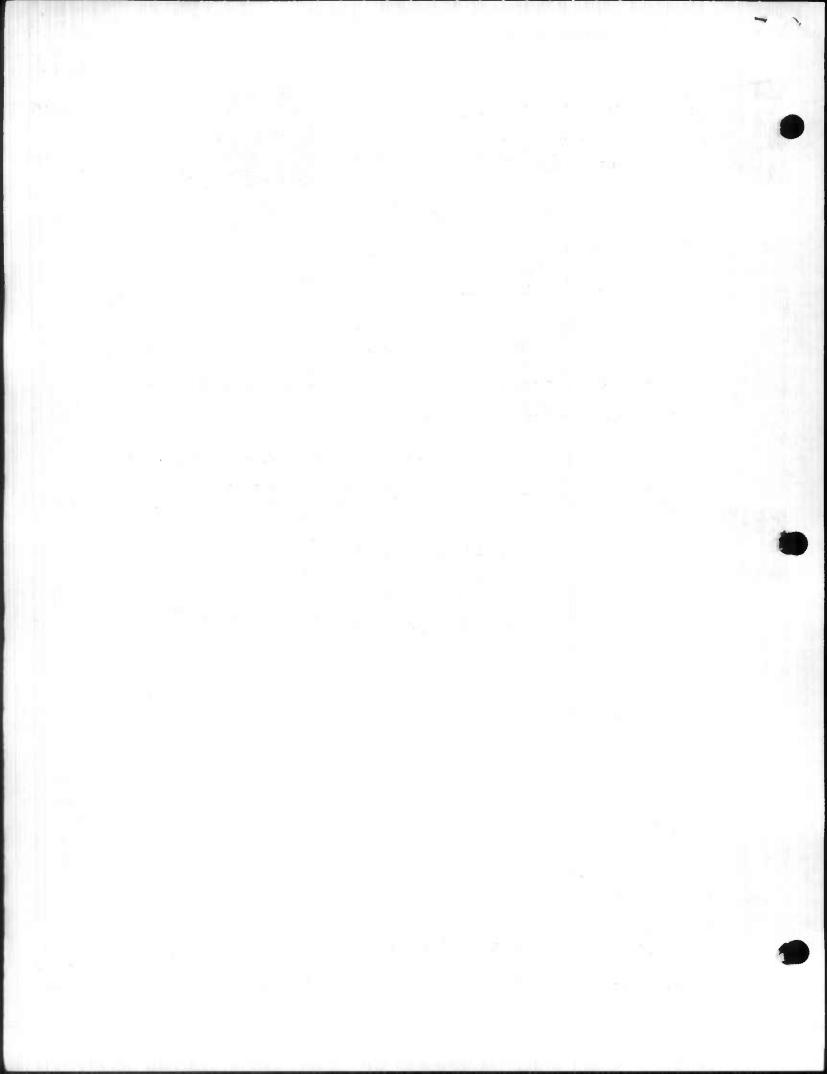
			Ce	rtificate of	Death		Reg. No.	See .	0010		
Physician	1. Decedent's Name (First, Middle, Later TED A AKST (A		·т)		2. Date of		Year	3. Time of Death			
/Medical		TED A. AKST (AARON T. AKST) le Facility Name (If not institution, give street and number) 4b. City, Town, or Lo							10:15 PM	1	
Examiner			00		ROCKV						
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Man Man	MD MONTGOMERY ROCKVILLE										
ar death with the Maryla thems 23s or 28s-f sho ner must be notified at uneral Director	10e. Street and Number	What Count	iry?								
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her death where 23 siner must	11. Meritel Stetus	12. Wes Decedent Ever in I Armed Forces?	U,S. 13.	Was Decedent of	Hispenic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No- 14. Rac	e - America ck, White, e			
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ad within 72 ho sof within 72 ho we than 'nature it, the Medical. Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	dent's Usual Occu	during most	of working	16b. Kind of Business/Industry					
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Co man oo	12		CLAI	MS ADJUS			CITY OF		RANSIT		
Be state as	17. Father's Neme (First, Middle, Last)			Name (First, Middle, Maiden Sumeme)							
To E	GEORGE AKST				FANN	IE WEINRI	WEINRIB				
Ma mary 27 te 27 te	19a. Informent's Neme/Reletionship (I	Type, Print)					or Rural Route Number, City or Town, State, Zip Code) ANNANDALE, VIRGINIA 22003-234				
altimore, mil. Peges 1 a parlment of he portant. If tem y Injury or othe Gs.	20a. Method of Disposition 1 Buriel 2 Cremetion 3 5 4 Donation 5 Other (Specific	Removel from State	cemetery, cre	osition (Name of ametory or other plant) ID MF:MOR		AUG**9,	FALLS C		wn, Stete H, VIRGIN	IIA	
Balt permit. Depart import any inj ance	21. Signature of Funerel Service Linuxee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCVILLE PIKE, ROCKVILLE, MARYLAND 2085										
N. T.	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory arrest, Approximate										
Physician	Shock, of heart fellore. List only	shock, or heart feilure. List only one ceuse on eech line.									
/Medical	Immediate Ceuse (Finel disease or condition	111	13 YEARS								
Examiner	resulting in deeth)	1	7 112/1/10								
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60, be executed ician and burial-transit	Sequentially list conditions	Due to (or es e conseguence of):									
o. execut an and inal-trar	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury										
68760, fficate be exp physician as the burial edical Expenses of the	triet mitiated events										
- 06 -	resulting In death) Lest	Due to (
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the d									ably 4 Unkno	own	
cor requ shoul		24e. V	es en autopsy enformed?	ava	ere eutopsy findings silable prior to mpletion of ceuse death?	S					
The lav							☐ Yes 2 XNo	10	Yes 2□ No		
Vital Relations The law certificate has rector, page 2 Be Comp	25. Was case referred to medical				26 Place			1	7.00 20.00		
f Vital ysician: The scartificate director, pa	examiner?	26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
of other this sale T:	27. Menner of Deeth	28e. Date of Injury (Month, Dey Year)	of 28c. inj		28d. Describe how injury occurred						
ding ding the After fune	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation			No							
Division of standing P is a that death. al Director: After tied in by the funers Certification:	3 Suicide 6 Could not be determined						28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
Division To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification.	29a. Certifier (Check only one) Check only one)										
o the o the omple	29b. Signature and title of conflict	d (Month, L	Day, Year)								
	1 Cmy	11/		D		AUGUST	8, 20	00			
30	20 Nome and	,,									
	DR RALPH V. BOCC				VE, RO	CKVILLE,	MARYLAND	2085	0		
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Sign	neture La	1-	1.						



State of Maryland / Department of Health and Mental Hygiene

26679 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month HNDERSON SCORGE 2000 /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Taylor Hall at Broadmeade Cockeysville Baltimore 7. Aga (In yrs. last birthday) 8 9 Yrs. Months Days Hours Min. Nov. 23, 1910 5. Social Security Number 339 - 24 - 7959 9. Birthpiaca (Stata or Foraign **Funeral** 18 M 2□ F New York Director Usual Rasidanca of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show th end Mentel Hygiene.
It's is marked other than "netural", or itema 23a or 28a-f show traumatic event, the Medical Example or must be notified at Maryland Baltimore Cockeysville 1 ☐ Yas 2 X No Director 10e. Street and Number 10f. Zip Coda 10a. Citizen of Whet Country? 13801 York Road T-367 21030 United States Funeral 12. Was Dacedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Biack, Whifa, afc. 1 Navar Married 2 Married 1 X Yas 2 No.
If Yas, Giva WWII
Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacadant's Education (Specify only highast grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coliega (1-4or 5+) Physician Own Business Dependent of Health and Annel Important: If Item 27 is any injury or or any injury or or one. 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be George Edgar Anderson Frances Jane Attridge 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) David K. Anderson/son 917 Leeswood Road Bel Air, MD 21014 20b. Placa of Disposition (Nema of camatary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Ramovai from Stata Chesapeake Crematory, Inc. 8/7/00 Beltsville, MD 4 ☐ Donafion 5 ☐ Other (Specify) CAFA Stephen D. Lohrmann P.A. 21. Signatura of Funaral Sarvica Licansaa Nardesty 8717 Green Pastures Drive Baltimore, MD Laura 21286 23a. Part1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Physician /Medical Immediate Causa (Final disaasa or conditior rasulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata cause. Entar Undarlying Causa (Diseese or Injury that initiated avents rasulting in daath) Lasf -18RILLATION the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical d for use es t detached f Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signe should be o by Completed 24b. Were autopsy findings availabla prior fo complation of causa of death? 24a. Wes an autopsy performad? page 2 certificate 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director. Be 25. Wes casa rafarred to madical axaminar? 26. Placa of Baath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 200 No Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 2 1 Yas After this 27. Menny of Death 28a. Data of Injury (Month, Dey Year) the funeral Certification: 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Naturai s efter death. 1 Yas 2 No 2 Accidant 6 Could not ba 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Piaca of Injury - At homa, farm, sfraat, factory, offica building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours or To the Funeral Completely filled Hospital 1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data end placa, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and pieca, and dua to tha cause(s) and mannar stated. Medical 29a, Cartifier 29b. Signature and titia of cartifian 29d. Data signed (Month, Day, Year) 29c. Licansa number 10 , 13801 York Rd, 31. Data filed (Month, Day, Year) AUG 0 9 Registrar

DHMH 16 Bey 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** August 0250 HENRY WALTER BOLDEN 2000 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number, 4c. County of Death **Examiner** herela Hosp, Ta Center corges If Under 24 Hrs. 5. Social Security Number 6 Set 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 100 M 2□ F 70 490-44-8264 Director Mar1, 1930 Missouri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at 1 Xes 2 □ No Capital Heights Maryland Prince Georges Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of Americ 20743 Funeral 6612 Weston Avenue 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ X & 2 □ No If Yes, Give Year or Dates: Race - American Indian, Btack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 27 Married Specify: Black 1 ☐ Yes XXX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturary injury or other traumatic event, to page. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementery/Secondary (0-12) College (1-4or 5+) Communication Specialist Federal Government 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Mamie Lawhorne Walter Henry Bolden 19a. Informant's Name Aetetionship Bolden, Wife 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6612 Weston Avenue, Capitol Heights, Maryland 20743 20b. Ptace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 premation 3 ☐ Remoyal from State Lee's Crematory 9 Aug 00 Clinton, Maryland 4 Donation Other (A) 22. Name and Address of Facility Pinckney-Spangler Funeral Home 524 8th Street, N. E., Washington, D.C. 20002 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** low Cancer with Complications /Medical immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of) for use es Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of deeth? been signed by the should be deteched 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy hes pe 2 After this certificate he funeral director, page 1 TYPE 2FTNO 1 □ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Catifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and piaca, and due to the cause(s) and manner steted.

that the death certificate be executed Records, P.O. Box 68760, Division of Vital

the Maryland

72 hours efter deeth

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

edicai

29a. Certifier

29b. Signature and title of cartifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -15751 SALVADOR SUL 31. Date filed (Month, Dey, Year) / AUG 1 0 2000

3001 22. Registrar's Signature

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Drive Cheverly MAR

29c. License number

HOU 53 927

29d. Date signed (Month, Day, Year)

Burns

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 31, Day 2000 Luvettia Brown 6:15am 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Months Days Hours 10M 20F 242-12-0095 76 Yrs Nov. 23,1923 Ashville, N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland | Prince George's Forestville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6549 Hill Mar Dr. #202 United States 20747 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yea 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Private Elementary/Secondary (0-12) College (1-4or 5+) Housewife 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown 19a, Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3606 Willow Ridge Ct. Forestville, Md. Selma Short / Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removal trom State 8/8/00 Chesapeake Crematory 4 Donation 5 Other (Specify) Beltsville, Md. 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 23a. Part1. Enter the disease, or complications that faused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feiture. List only one cause of each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximate Interval Between Onset and Death tmmediate Ceuse (Finat disease or condition resulting in death) Due to (or as a consequenca of):

Physician /Medical Examiner

Examiner

Physician/Medical

Be Completed

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

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Mental

of Health

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other algorificant conditions contributing to death but not resuffing in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yaa 2 No

24a. Was an autopsy performed? 1 Yes 20 No

28d. Describe how injury occurred

24b. Were eutopsy tindings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 20 No

Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify)

27. Manner of Delit 1 ANatural 5 Pending investigation 2 Accident

6 Could not be determined

28b. Time of

28c. Injury at Work? 1 Yea 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a. Certifier (Check only one)

3 Suicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 238) (Typ

Sam Tellawi, M.D.

31. Date tiled (Month, Dey, Year) AUG 0 9 2000 37. Registrar's Signature

Registrar DHMH 16 Ray 6/95

Director:

within 2 To the

Division

ER

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4b. City, Town, or Location of Death **Physician** 1000 JE ANETTE S. BROWN /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Keverl Prince George 6 espes Hospital If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vis. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Min. Days Hours 1 M 2 F Months Director 228-22-9368 of Residence of Decades May 14, 1915 Fredericksburg, VA Usuel Re 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1€ Yes 2 No Director 238-7 Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 238 303 70th Street 20743 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 à 1 ☐ Yes 2 1 No Specify: Specify: African American þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 11 Clerk Government permit. Pages 1 and 2 should be fire Department of Health and Mental Hy Important: If Nam 27 is marked offin any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 86 Andrew Stewart Matilda Morton 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn E. Davidson - Niece 1668 Tamarack Street, N.W., Washington, D. C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removet from Stete 8/16/2000 4 Donation 5 Dother (Specify) Arlington National Cemetery Arlington, VA 21. Signature of Funeral Service License 22. Name end Address of Fecility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C. 20019 23a Part 1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, chock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Articioschentic Cardisunsenlar Disease /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burial-transit certificate be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): 980 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed The law page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: 25. Was case referred to medical axaminer?

127es 2 No Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how Injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1- Netural death. 1 Tyes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 Hospital 1 Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signeture and title of certifier 29c. License numbe

State Registrar 31. Dete filed (Month, Day, Year)

AUG 0 9 2000

DHMH 16 Ray 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

Registrar's Signature

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				Certin	ficate of L	Death		Reg. No.	26683
sician	1. Decedent's Name (First, Middle,	Last)				46.0	2. Date of Do	eath Day	3. Time of Death
dical	Blanche Evelyn 4a. Facility Name (If not Institution)				A	b. City, Town, or	Augus	st 7. 2	000 1:52am
iner	Fahrney-Keed			m <i>e</i>		Boonsk		,	ington
Н		-Sex		. lest birthday)	Under 1 Year onths Days	If Under 24 Hrs Hours Min	8. Date of Bi	rth ev Yearl	Sirthplace (State or Foreign Country)
	215-26-2378 Usual Residence of Decedent	1□M 2⊠F	90	Yrs.	Olitina Days	TIOUIS WIII	Oct.	3, 1909	Pennsylvania
	10a. State 10b. County		10c. C	ity, Town or Locati	on				10d. Inside City Limits
2	Maryland Washin	gton	В	oonsboro					1 ☐ Yes 211X No
	10e. Street and Number				10f. Zlp Code			10g. Citizen of V	What Country?
5	8507 Mapleville	Road 12, Was Dece	dent Ever in I	10 10 100	21713	annia Osiain? (6	`aaaik.	U.S.A.	a American Indian
runeral	1 Never Married 2 Married	Armed Fo	rces?			spanic Origin? (5 n, Mexican, Puer	to Rican, etc.)	Blac	e - American Indian, ck, White, etc.
2	3€Widowed 4 □ Divorced	If Yes, Giv Yaar or D		10	Yes 2000	Specify:		Specify	White
etec	15. Decedent's (Specify only highest			16a. Decedent	's Usual Occupa d of work done d	ation luring most of wo	rking	16b. Kind of Bu	usiness/industry
Completed	Elementary/Secondery (0-12)	College (1	-4or 5+)	Homemak				Own Ho	ome
De C	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle	, Maiden Sumam	
0	Jacob Franklin E	tter				Viva :	Smith		
	19a. Informant's Name/Reletionship							per, City or Town,	
	Caralee B. Bixle	r - Daug		2036 Kd		e Road,	Silver	Spring,	MD 20905 City or Town, State
	1 Burlal 2 Cremation 3 4 Donation 5 Other (Spe	□Removal/from	State	cemetery, cremeto	ory or other plece	· 1			101 100
	21. Signature of Funeral Service Lice	1	F	22. No	In Ceme	s of Facility		Brentwo	ood, MD
	1/6/	11.		Gas	ch's Fu	neral Ho	ome, P.A	attsvill	l - MD 20701
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that c	auself the dea	th. Do not enter the	ne mode of dying	g, such as cardia	c or respiratory	arcsv111	Le, MD 20781 Approximate Interval Between
		, • • • • • • • • • • • • • • • • •							Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a		Dynpa	282				1 milh
			Due to	or as a consequer	ice of):				
ā									10- 27
	Sequentially list conditions	b		or as a consequen	Acai	any-			Int
ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b		or as a consequen	Acai	my			Int
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ĭ	if any, leading to Immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last	cd	Due to (or as a consequen	ce of):	on in Part I.			ntribute to the cause of death?
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State Registrar

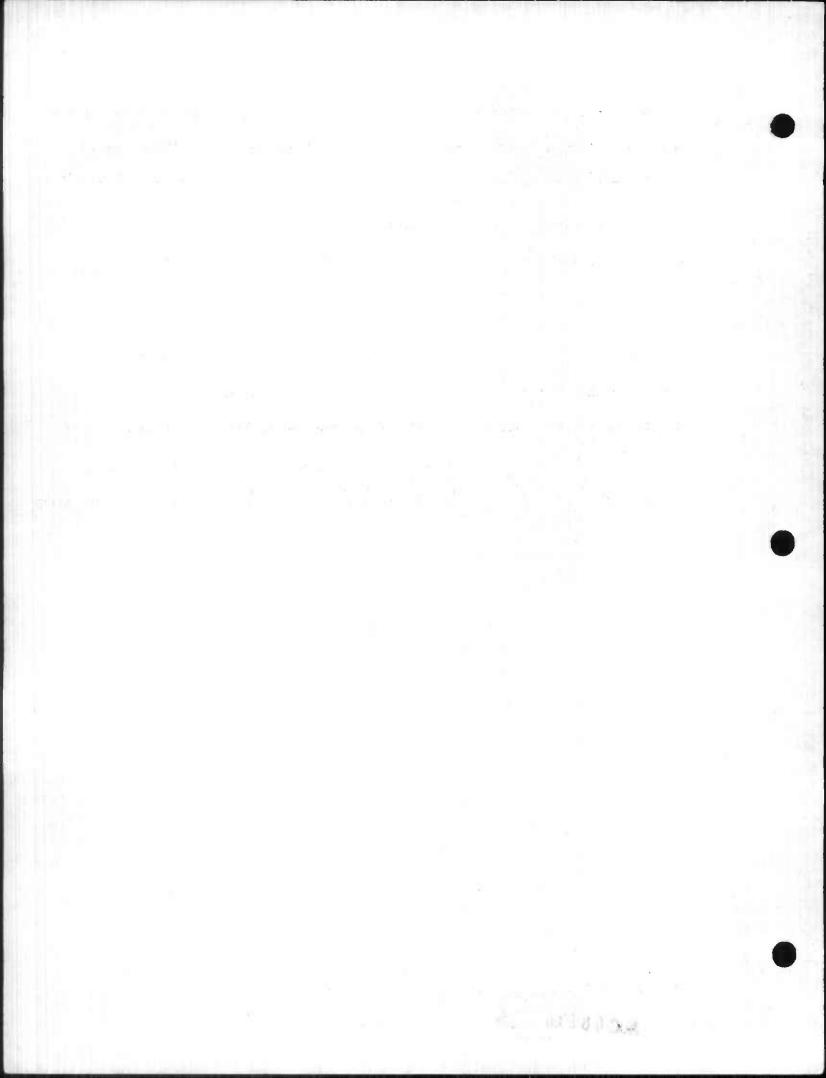
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Dr. Vasant Datta, 334 Mill Street, Hagerstown, MD

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

33. Assultation



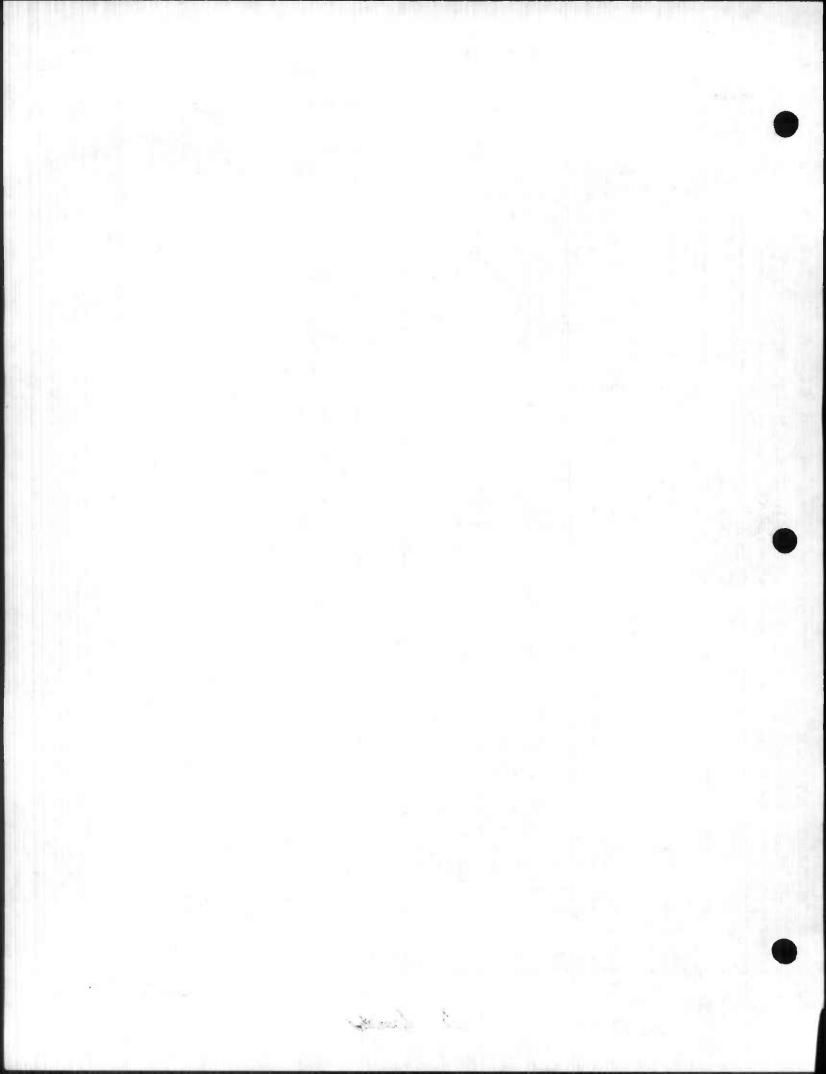
00-4375-031 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene 26684 UNK. 00-203 Certificate of Death David Bolon 1 Decedent's Nama (First Middle Last) 2. Date of Death 3. Time of Death **Physician** DAVID STUARDO BOLON AUGUST 04, 2000 02:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROUTE 198 AND WOOTENS LANE BURTONSVILLE MONTGOMERY 7. Age (In yrs. last birthday) 3 1/rs. If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-24-69 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1€M 2□ F 215-39-4535 Guatemala Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at Silver Spring 1 Yas 2 No Montgomery Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Guatemala 20906 3962 Bel Pre Road Apt. 7 234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14 Baca - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 6 Baltimore, Maryland 21215-0020 2□No Specify: Guatemalan Specify: Hispanic PV 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trash-Away Co. 10th Laborer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fit Health and Mental H Maria Angelina Guzman de Bolon Jose Antonio Bolon Ith and Menta 27 is marked traumatic e 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3962 Bel Pre Rd., Apt. 7 Silver Spring, Md. 19a. Informant's Name/Relationship (Type, Print) 20906 Joel D. Bolon Guzman Health Ism 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition b 1 Burial 2 Cremation 3 Removal from Stata Ciudad Capital Family Cemetery 08-14-00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansi 22. Name and Address of Facility CC0257 Bacon Funeral Home, Inc. Washington, D. C. 20010 3447 14th St., N.W. ther the disease, or complications that caused the heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last the burial-tran Due to (or as a consequence of): Box 68760, Due to (or as a consequence of) 88 USB 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown 3 Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 15 Yes 2□ No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Injury at Work? After Division 5 Pending investigation 1 Natural Pedestran Struck by vehicle 0127 aftar death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Straet and Number or Rural Routa Number, City or Town, State) Rt. 198 + Westerns Lane 28e Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) ipletely filled in by 4 ☐ Homicide Burtonsville Street Md 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. Licanse number OCME AUGUST 04, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ose aner 111 Penn Street, Baltimore, Maryland 21201 D 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00 25585

				Cer	tificate	of E	Death			Reg. No.			_ 00	00
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edicai iminer	4a Facility Name (If not institution, give		r)			4t	b. City, Tow	m, or Loca	tion of Deat	h 4c.	County o	f Death		
	University of Ma	rvland Me	dical C	ente	r		Bal	timor	re		1	N/A		
ıl r	5. Sociel Security Number 6. 5		Age (In yrs. last		If Under 1	Year Days	If Under 2 Hours	4 Hrs. 8. Min.	Date of Bir (Month, De (Pril	th Year)	73	9. Birthpi	lace (State o	
н	N/A Usuat Residence of Decedent			1				-	PITT	4,17	15	PILL	ippine	25
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cto	Moalboa	.1	Cebu	1 City	~									2010
Il Director	712 Bliss Tunga				101. Zip C						izen of Wi		try?	
era	11. Marital Status	12. Was Deceden	nt Ever in U,S.	13. V	Vas Deceder	nt of His	spenic Orig	in? (Specif	y Yes or No				an Indian,	
by Funeral	1 ☐ Never Married ŽÕ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 25 If Yes, Give Year or Dates	No		Yes, specify		Specify:	Puerto Rio	can, etc.)		Black Specify:	White,	ipino	
	15. Decedent's E	ducation	1	8a. Deced	ent's Usual (Occupe	tion	-1.1		16b. Ki	nd of Bus		-	
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To	Jose Burgos, Sr.				100									
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	20a. Method of Disposition 12 Suriel 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specification)		ceme	etery, crem	sition (Name netory or othe Cemete	er place	9)	Auc	gust, 2000	Moal	boal ippi	, Ce	ebu Čit	ty,
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	23a. Part1. Enter the disease, or com	tomes)	Loup		4522L						/1191	nia	Approximat	
	shock, or heart failure. List only	one cause on each	line.	Spriot Grite	er the mode t	or dying	, such as c	ardiac or i	espiratory e	iii esi,		1	Interval Bet	ween
	Immediate Cause (Final disease or condition		Molt	Jan J	e I	1	JUV	riei				1	Oriset and t	Count
er	resulting in death)		Due to (or as	a conseq	uence of):		1							
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S	Part It. Other eignificant conditions of	contributing to deeth	but not resultin	g in the ur	nderlying cau	se give	n in Part I.		23b. Dld	tobacco	ues cont	tribute to	the cause	of death?
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y F														
Completed by Physician/									24e. Was	en autor	psy	ave	ere autopsy t eileble prior t	to
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3	25. Was case referred to medicat examiner?	Hospital		LA		Out-		of Death (Check only	one)				
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ii.	27. Manner of Death 1 Natural 5 Pending	28a. Dete of In (Mpnth, D	ojury Dey Year) 28	b. Time of Injury	280	. Injury		-	d. Describe	how Inju	ny occurre	ed		
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tific	3 Suicide 6 Could not be determined	209. Placa of I	hjury - At home etc. (Specify)	, farm, str	eet, fectory,	es more		28	f. Location City or To	(Street ar	nd Numbe	or Aura	Aoute Num	nber,
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cal		nysician: To the bes							d due to the				tated the causes	e)
	one) 2(A Medical Exam	niner: On the basis and manner s	or examination steted.	and/or inv	restigation, in	n my op	oinion, geati	n occurred	at the time	, date end	з рівсе, в	ng que to) the ceuse(s	s)
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	phe	100	1 d = 46 /h =)-\ CT	D-i-e)	O.	. C . PI . I	٠.		A	ugusi	L I,	2000	1
	30. Neine and address of person who	completed cause of	deeth (Item 23						100	3				
	J. LIF POPU COC	te //			Penn S	tre	et, B	altim	ore,	Mary.	Land	2120	J1	
ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1										

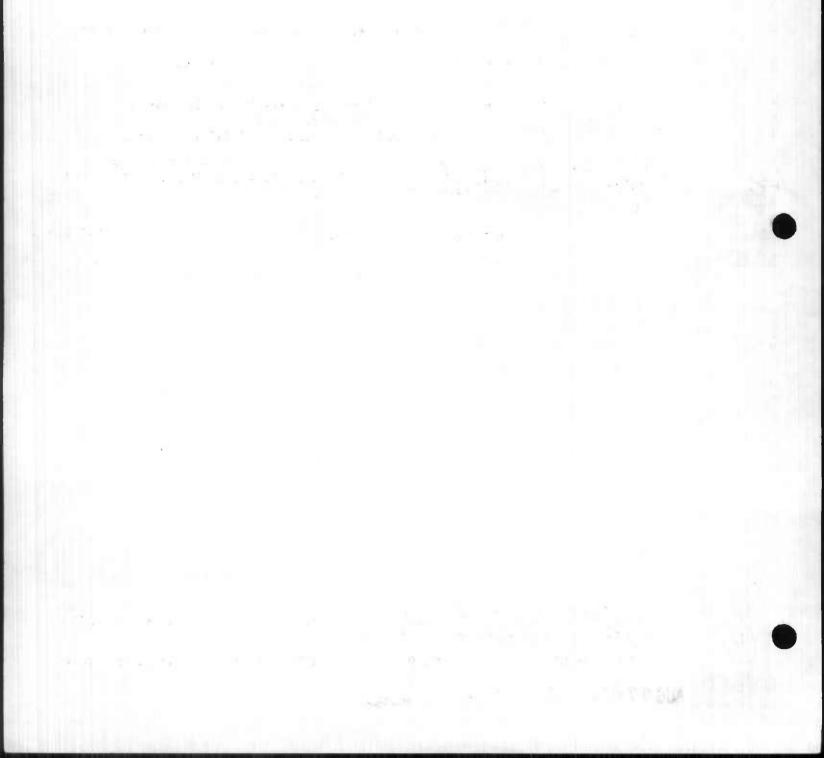
State of Maryland / Department of Health and Mental Hygiene

26686 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August **Physician** 2000 Jerome Francis Blakeney, Jr. 7:30AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death **Examiner** Ft. Washington Ft. Washington Hospital Center Prince George's If Under 1 Year 8. Date of Birth (Month, Day, Year) 76 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthdey) **Funeral** 10 M 20 F Months Days Hours Min Wash., D.C. 212-08-9366 24 Yrs Director Usuai Residence of Decedent the Marylend 10b County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours efter death with the Marylen than Manthall Hygiene.
7 is marked other than "natural", or frems 23s or 28s-f show traumatic event, the Manthall Examines must be notified as 1 TyYes 2 □ No Maryland Prince George's Ft. Washington Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7507 Epping Ave. 20744 United States Funerai 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Black. 1 ☐ Yes 2 PNo Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Coilege (1-4or 5+) Etementary/Secondary (0-12) Post Trademark Admin. Government 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Jerome Francis Blakeney, Sr. Tracey B. Tyler 10 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun once. Tracey B. Tyler - Mother 7507 Epping Ave., Ft. Wash., MD 20b. Place of Disposition (Name of Car. Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/9/2000 Forest Hills Memorial Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 nter the disease, or complications that caused it seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cryptococcal Meningitis 3-4 Weeks Examination Due to (or as a consequence of) Examiner HIV Years certificate be executed physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 esn signed by the etta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen 21 No 1 Tyes 2 No 1 Yes certificate i or Attending Physician: after death. Director: After this certific funeral diractor, Be 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at to the Funerel D 29a. Certifier 1🖰 Cartifying Physician: To the best of my knowtedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tile of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D32807 August 3, 2000 m 23a) (Type, Print) d cause of death (Ite Herbert Washington, M.D. 11701 Livingston Rd., #205; Ft. Wash., MD 20744

State Registrar

31. Date filed (Month, Dey, Yeer)
AUG 0 7 2000

32. Registrar's Signature



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State of Maryland / Department of Health and Certificate of Death	Mental Hygiene	00	2668
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	Funeral Director	5. Social Security Number 6. S		e (In yrs. lest b	irthday) If Undar 1 Yea Months Days		8. Date of Birt Month, Dej Feb. 12	, 1926	Cour	place (State or Foreign ell, W.VA.
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Maryland 21215-0020	ar, or them Example: by Fund	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedant Armed Forcas? 1 Yes 2 If If Yes, Give Yaar or Datas:		13. Was Decedent of If Yes, specify Cu		o Rican, etc.)	Blac	k, White,	etc.
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yla	Men Men To	Charles W. Vogt					Swisher			
Aar	the state of the s	19a. Informant's Name/Relationship (19	b. Meiling Address (Stree		ural Route Numbe	er, City or Town,	State, Zip	Code)
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Z	992.00	Kork. K.	des 11		6160 Oxon	Hill Rd.	Oxon hil	11. Md.	2074	5
		23a/Part1/Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not enter the mode of d	ying, such as cardia	or respiratory ar	rrest,		Approximate Interval Between
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	/Medical Examiner	tmmediate Cause (Final disease or condition resulting in death)	a 131	layer	of 1m	eunou	16C		1	1 cearl
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Records,	v requires that been signed b should be dete						24a. Was	an autopsy	24b. W	ere autopsy findings
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R	The law page 2	Market Street					10	Yes 210 No	11	☐ Yes 2☐ No
ta	certificate rector, pag	25. Wes case referred to medical				26. Place of De.	ath (Check only o	one)		
>	Physician: this certific rel director. TO Be	examiner?	Hospital: 1 Inpatie	ent 2 ER/C	Outpatient 3 DOA	Whor:	tome 5□ Resid		er (Speci	ty)
0	Affer th funerel	27. Menyler of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry Year) 28b.	Time of 28c. In	ury at	28d. Describe	how injury occur	red	
0	Attending or death. After the fune fune fune fune fune fune fune fun	2 Accident investigation	1	, , , ,		☐ Yes 2☐ No				
Division of Vital	To the Hospital or Attending Parties 24 hours after death or to the Funeral Director. After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Inj building, et	ury - At home, c. (Specify)	farm, street, factory, offic	0	28f. Location (: City or Tox	Street and Numi vn, State)	ber or Run	al Route Number,
	C C C									
	the Hospital or At thin 24 hours after the Funeral Direct impletely filled in by Medical Certifi	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar			je, death occurred at the nd/or investigetion, in my	time, dete end piece opinion, death occu	e, end due to the urred at the time,	cause(s) and m dete end place,	anner es s end due l	stated. o the cause(s)
	Med mple	29b. Signature and tale of certifier	and manner st	a(9 0.	29c 1 ice	nse number	. 1	29d. Date signe	d (Month	Dev. Year)
	FIF	VILLEN	0	. 1	Man of .	> 21/	3			-
	(10)	WX7 UM	1/	1D H	curelly o	0-7-	, , ,	00	,0,	3.00
	(0)	30. Neme end address of person who								
1		Laxmi Berwa, M.D.	//00 01d	Branch	Ave. Clint	on, Md. 2	0735			

Registrar

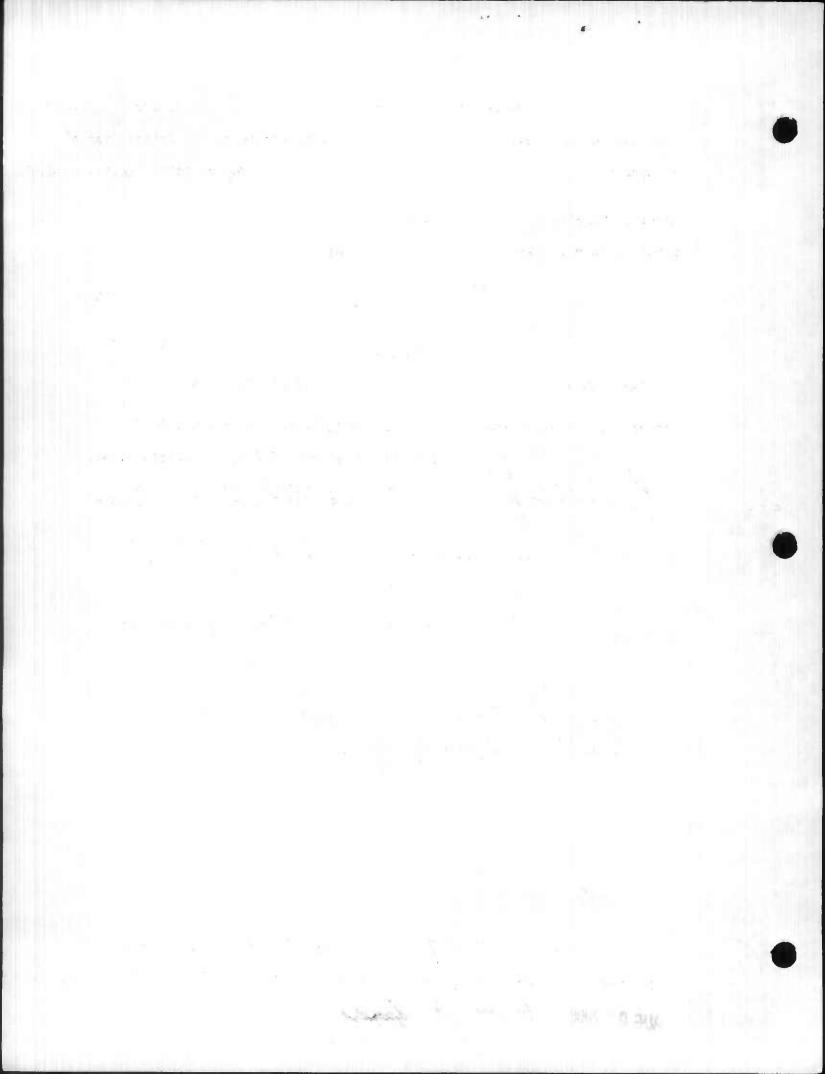
DHMH 16 Rev 6/95

MEDIUM THE FOREST

			State o	f Marylan		artment rtificate			nd M	ental Hyg R	iene	0 21	6688
	ysician Medical	1. Decedent's Nama (First, Middle, Las		yn Robey	Buss	ey				2. Data of Deat Month August	2, 200	Yaar O 2	Tima of Deeth: 20PM
	aminer	4a Facility Nama (If not institution, give Fort Washington H						4b. City, Tov	•	ngton	4c. County	of Death e Geor	ge's
Fund Direct		5. Social Security Number 6. Se		7. Aga (In yrs. I 88	ast birthday) Yrs.	If Undar Months		If Under 2 Hours	4 Hrs.	8. Data of Birth (Month, Day, May 28,	Year)	9. Birthpiace	(Stata or Foraign Head, MD.
tar death with the Maryland frems 23s or 28s-f show	ttedat	Usuat Rasidanca of Decedant 10a. Stata 10b. County Maryland Charles			, Town or Lo	ocation							nsida City Limits
with the	I be northed	10e. Street and Number 16301 Holly Hill	Drive			10f. Zip	Coda 601			1	0g. Citizan of W	hat Country?	
	by Funeral	11. Marital Status 1 Navar Married 2 Married XXWidowed 4 Divorced		2 X No ⁄a		Was Deced	lant of H	lispanic Orig an, Maxican, Specify:	in? (Spe Puarto I	cify Yas or No- Rican, atc.)	Blac	- Amarican to k, Whita, atc. White	ndian,
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		Elemantary/Secondary (0-12) 17. Fathar's Nama (First, Middla, Last)	Coilega (1	1-40r 5+)	Home	maker		18. Mothai	r's Name	(First, Middla, M	At Ho		
Maryland d 2 should be file th and Mental Hy 7 is marked oth	To Be	Wallace Robey						Minn	ie I	rene Ga	tes		
of Haal	y or other traus	19a. Informant's Name/Relationship (7 Richard A. Bussey 20a. Mathod of Disposition 1 \(\) Burial 2 \(\) Crametion 3 \(\) 4 \(\) Donation \(\) Other (Specify	Jr/Gra	Stata 20b. P		08 In	diar na of thar pla	Lane				1 City or Town,	
Canal Page Page Page Page Page Page Page Page	ical iner	23a. Pagi. Enter the disease or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	nications that cona oausa on a		G 6 n. Do not an	eorge 160 O: tar tha mod	P. xon a of dyir	Hill ng, such as	Fun Rd.	eral Ho Oxon Hi rraspiratory arr	11, Md.	20745 Ap Inti	proximete arval Batwean sat and Death
BOX 56/750, saft cartificate be executed attending physician and	use as the bural-transit in/Medical Examiner	Sequentially list conditions, if any, taading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated evants resulting in death) Last	~/	oni c	r as a consecutive as a	ruci	lative	on Pu	/mc	nory ?	Disea	se	
hat the death	etached for use as Physician/Me	Part II. Other significant conditions co	ontributing to de	eath but not rasi	ulting in the u	inderlying c	ausa giv	van in Part I.		23b. Did to	_/		cause of death?
Hecords, a law requires to has been signe	Completed by R	lumbar	/ 4	pon	dy 1	OSI	7			24a. Was a perform	med?	availat compl of daa	
Ital	Be Co	25. Was casa rafarred to medical						28. Placa	of Daath	1 Check only or		TUT	as 2 No
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DIVISION or Atlanding after death. Director: After	led in by the funera Certification:	2 Accident invastigation 3 Suicide 6 Could not be determined	28a. Placa	of Injury - At he	oma, farm, st	M raat, factory		Yas 2□I		28f. Location (S City or Town	treet and Numb n, Stete)	er or Rural Ro	outa Number,
Hospita 24 hours Funeral	pietely filled edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	iner: On the b										
To the To the	Mex	29b. Signatura and titla of certifiar		01	1			sa number	191		9d. Data signe	d (Month, Day	v, Year)
(19	/	30. Nema and address of person who of BEJJENICISC	complated caus	sa of death (item	6196	Print)	on /	rell R	oa d	Suite	520	OXO	n nill

State Registrar

DHMH 16 Rev 6/95



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/Medica	1	Helen L. Facility Nama (If not institution		ttle				4h City Toy	vn or Lo	Augus1			2000 of Death	08:2	8 A.
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d Me	2	Abe Griffin 9a. Informant's Name/Relations	ship /Type	a Print)		19b. Meiling Ad	drace (Stra					Town !	State Zin C	ode)	
th en 17 la 1	"	Bernarr M. Ba				10622									20
Hee	20	0a. Method of Disposition			20b. Pl	lace of Disposition emetery, cremetor			1	Date			City or Tow		
T: H		1 ☑ Burial 2 ☐ Cremation	3 □Re	moval from State	Ce	emetery, cremetor									
permit. Fages 1 and 2 should be littled with Department of Heelth and Mentel Hyglene. Important: If tem 27 is marked other than any Injury or other traumatic event, Ital MODE.	2	4 □ Donation 5 □ Other (S	Specify)			urrection 22 Nam Ale	n Ceme	ress of Facilities S. P	ope	/15/00 Funera	1 Hom	es		007/7	
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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of yeeth (Item 23a) (Type, Print)

O.C.M.E.

August 10, 2000

THEODORE M. King 31. Date filed (Month, Dey, Year)
AUG 1 7 2000 37. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

State Registrar

BONDS JR.

Physician

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

JERRY

1. Decedent's Nama (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, Certificate of Death

Reg. No. Day

2. Data of Death

Month

	Exam
	Funera Directo
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or frams 23a or 28a-f ahow any injury or other traumatic avent, to a Maryland Exercise must be notified and once.
0	Physician /Medica Examiner
	and and It-transit

Box 68760

of Vital Records, P.O.

Division

8:58A.M. AUGUST 20,2000 JERRY ALLEN BONDS, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) ELKTON CECIL 55 PLEASANT HILL DRIVE 8. Date of Birth (Month, Day, Yea Jan. 23, If Under 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) Year) 1 M 2 □ F Months . Days Hours Min Yes 1979 21 Maryland 215-96-2000 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 No Director Maryland Cecil Elkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 U.S.A. 55 Pleasant Hill Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 1 X Naver Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Food Store Meat Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Jo Ann Yancheski Jerry Allen Bonds, Sr. 19b. Meiling Address (Straat end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) 919 Pirates Court, Edgewood, MD 21040 Jerry A. Bonds, Sr. (Father) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 8/23/00 Bel Air, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Addrass of Facility Schimunek Funeral Home of Bel Air, Inc. Mars T. 610 W. MacPhail Road, Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. — only one causa on each lina. ACUTE NARCOTIC INTOXICATION Immediate Cause (Final disaase or condition resulting in death) Due to (or as a consequence ot) Examiner Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca ot): ed by the attending physician detached for use as the buri The law requires that the deeth certificate be a Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4€ Unknown Completed by 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? this certificate has 1 Yes 2 No Yas 2 No director, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 2 1 Yes 2 No 28a. Date of Injury
FOUNCE
8-20-00 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: al or Attanding P s after death. Il Director: After od in by the funan Found: M 5 Pending investigation 1 Netural UNKNOWN 1 Yes 2 No 2 Accident 6 X Could not be determined 28e. Place of Injury - At home, term, street, factory, offica building, etc. (Specify) FOUND AT RESIDENCE 3 Suicide 28t. Location (Street and Number of Rural Route Number HILL City or Town, State) 55 PLEASANT HILL 4 Homicide filled In DR. ELKTON, MD To the Hospital o within 24 hours at To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian with as Varines O.C.M.E. AUGUST 21,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (hute MO Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State

Registrar

2000

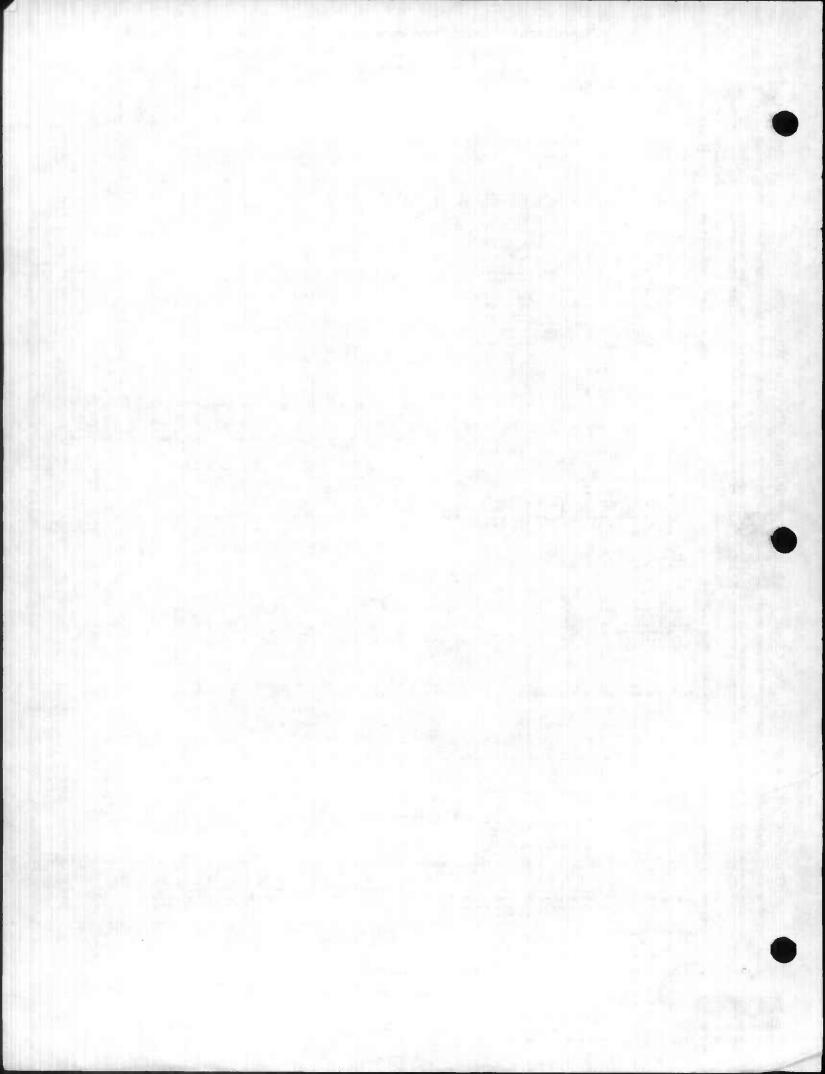
AUG 2

31. Data filed (Month, Day, Year)

Jacks

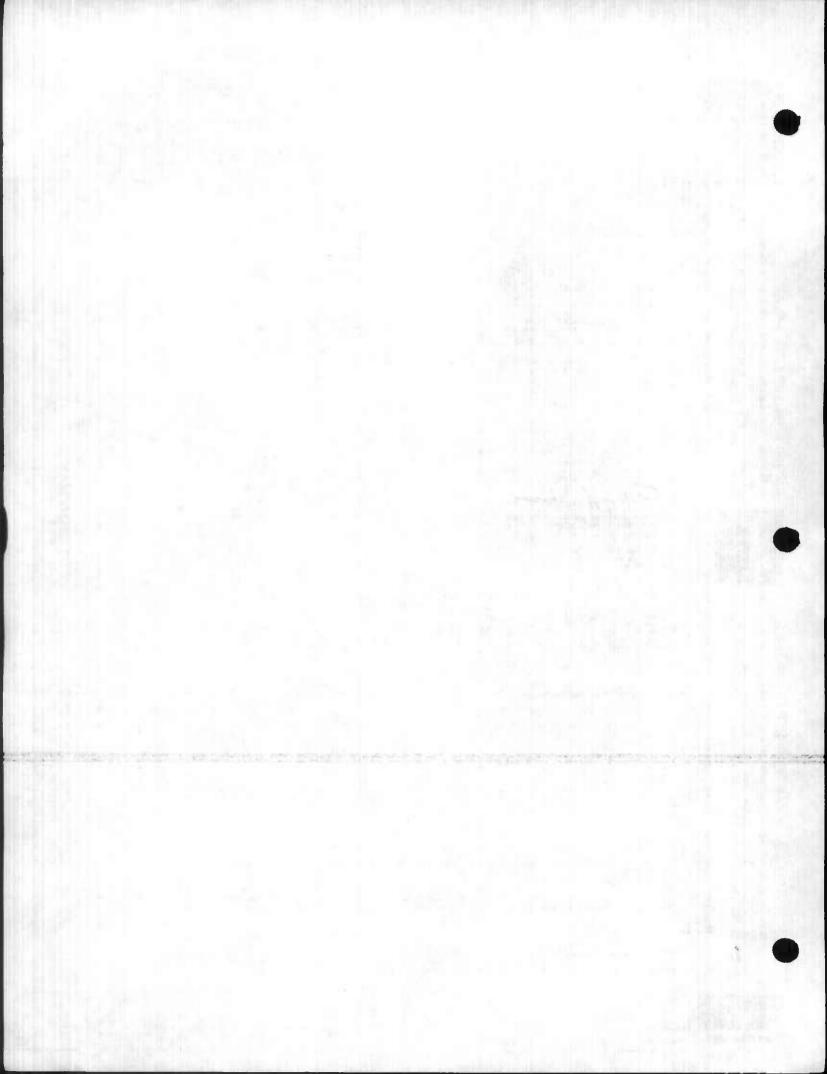
32. Registrar's Signature

Ryceral



State of Maryland / Department of Health and Mental Hygiene 00 26691

				Cer	tifical	te of L	Death			Reg. No.			
NO.	1. Decedent's Name (First, Middle, La	st)	1145						2. Date of De			3. Time	of Death
Physician	Pantrian V	Dagai							Month	5. 2000	Year	4:0	Opm
/Medical	Beatrice K 4a Facility Name (If not institution, give	Bassin				14	h City To	own or I	_ocalion of Death				_
Examiner			01/			1_			_oodion or bodi				
NA.	Carriage Hill -						ethe			Montg		4	
Funeral	5. Social Security Number 6. S	Sex 7. I□M 2□XF	Age (In yrs. I		Months Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Oct. 23	th y, Year)	9. Birthp	lace (State	e or Foreign
Director	578-60-3608	1 W 2 2 3 4		85 Yrs.					Oct. 23	3, 1914	New	York	
D	Usual Residence of Decedent												
Page 1	10a. Stale 10b. County		10c. City	, Town or Lo	calion						1		City Limits
to the to	DC N/A		Wa	shingt	on							1 🗆 Ye	es 2K No
with the Ma or 28e-fa be notified Director	10e. Street and Number					p Code				10g. Citizen of V	Vhat Coun	ntry?	
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flor death of their state of their s		12. Was Decede	nt Ever in 11	S 12 V	Nac Door	dent of Hi	enanic Or	igin? (S)	pecify Yes or No		e - Americ	an Indian	
C Per C	11. Mantal Status	Armed Force	s?	. H	Yes, spe	cify Cuba	n, Mexice	n, Puerto	o Ricen, etc.)		k, Whita,		
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2		1	I □ Yes	2 No	Specify:			Specify	. Whi	ite	
D P		Year or Date	es:										
ad within 72 ha ygierne, wer than *rastur f, the Medical Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deced (Give	lent's Usu kind of wo	al Occupi ork done d	ation fu <i>ring</i> mos)	st of wor	king	16b. Kind of Bu	isiness/Inc	dustry	
d within 72 hours at pierro. r than "natural", or the Medical Exam ompleted by I	Elementary/Secondary (0-12)	College (1-4	or 5+)										
2 52 2 4 7 7		5+		Speed	ch Pa	thol	ogist	:/Te	acher	DC Pub	lic S	Schoo	1
0 18 BIE	17. Father's Name (First, Middle, Last,)					18. Moth	er's Nan	ne (First, Middle,	Maiden Sumam	(6)		
Menta Menta To B	Nathan Kellner						Anr	ne F	ern				
or o	19a. Informant's Name/Retationship (Type, Print)		19b. Mailin	ng Addres	s (Street I	and Numb	er or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)	1 54 45
The state	Colonel Jules Bas			2891	Andr	hon	Torre	200	NW Was	shington	DC	2000	8
Page 1	20a. Method of Disposition	75111	20b. Pi	lace of Dispos	sition (Na	me of		100,	Date Nas	20c. Location -			0
Pages 1 a nent of Heam ent: If Nem.	1⊠ Burial 2 ☐ Cremation 3 ☐	Removal from Sia	Ci Ci	ametery, crem	natory or	other plac			8/14				
E THE	4 Donation 5 Other (Specif	y)	Arl	ingtor	n Nat	1ona	I Cen	nete	ry 2000	Arlin	gton,	, VA	
1 1 1 1 1 1	21. Signature of Funeral Service Licer	nsee		22	. Name a	nd Addres	s of Facili	ity	E 1	II.			
20158	TRACO A -	hence.		50	00 Un	iver.	sity	Blv	d. W. Si	Home I	nc. ring	MD 2	0901
	23a. Part1. Enter the disease, or com shock, or heart tailure. List only	plications that cau	sed the death									Approxim	nate
Dhusisian	shock, or heart tailure. List only	one cause on eac	h line.								1	Interval B Onset an	ietween id Death
Physician // // // // // // // // // // // // //	Immediate Cause (Final										1		
Examiner	disease or condition resulting in death)	a Hypert	ensive	Heart	Dis	ease					1		
CHAPPED I	1 resulting in ceatily		Due to (or	r as a conseq	uenca of)	:							
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cute nd rans	Sequentially list conditions.	0.		as a conseq									
The residence of	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D									1		
death certificate be executed eath certificate be executed of a strength of for use as the burial-transit sician/Medical Examir	that initiated events	c. Dement		as a consequ	uence of)								
ficat ficat	resulting in death) Last		Due 10 (0)	as a conseq.	001100 017	•							
attending of for use as	Lean Land	d									1		
attend for us											1		
	Part II. Other aignificant conditions of	contributing to deat	h but not resu	liting in the ur	ndertying	cause give	en in Part	1.	23b. Did	tobacco use co	ntribute to	o the caus	e of death?
d by detac	Market Market 1981								10	Yea 2□ No	3 Pro	bably 4	₩ Unknown
								_					
auld au										an autopsy med?		ere autops ailable pric	sy findings or lo
) > 00 =						100			pone	Amour	co	mpletion o	
The law ate has b page 2 s	THE SECTION AND ADDRESS OF									-	1100		
F # 8 0									10	Yes 2X No	11	Yes 2	□No
certificate irector, par	25. Was case referred to medical examiner?							e of Dea	ath (Check only	one)			
2 2 2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	t 3□ D	OA Oth	Br: 4GN	ursing H	lome 5 Resi	dence 8 DOth	er (Specif	(y)	
a Ph	27. Manner of Death	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		28c. Injun Worl	at		28d. Describe	how injury occur	red		
oding Figh.: After a funeral	1 Natural 5 Pending 2 Accident investigation		Day roal,	inquiy	М		Yes 2	No					
Attending ar death. ector: After fune by the fune liftication	3 ☐ Suicide 6 ☐ Could not b		Injury - At ho	me, farm, str	eet, facto	ry, office			28f. Location (Street and Numb	per or Rure	al Route N	um <i>ber</i> ,
tal or Attending P is after death. al Director: After it ed in by the funer: Certification:	4 Homicide	building,	etc. (Specify	1)					City or To	wn, State)			
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To the i within 2 To the comple	one)	and manner	stated.			ha 4.1				and Date state	4 194	Day Va	-1
To To	29b. Signature and title of certifier				29	c. License	number			29d. Date signe	u (Month,	Day, 1981	
16	I Teromer	0 0-1)	05-49 C	1	D	473.	30			August	7. 20	000	
	30. Name and address of person who										,		
E E BYLL	Thomas V. Joseph					1370	Root	ray 1 1 1	le, MD 2	20852			
State	31. Date tiled (Month, Day, Year)		istrar's Signal					V.I.I.	re, rid 2	20074			
State Registrar	AUG 0.8.20		men	19.	10	ocks	1						

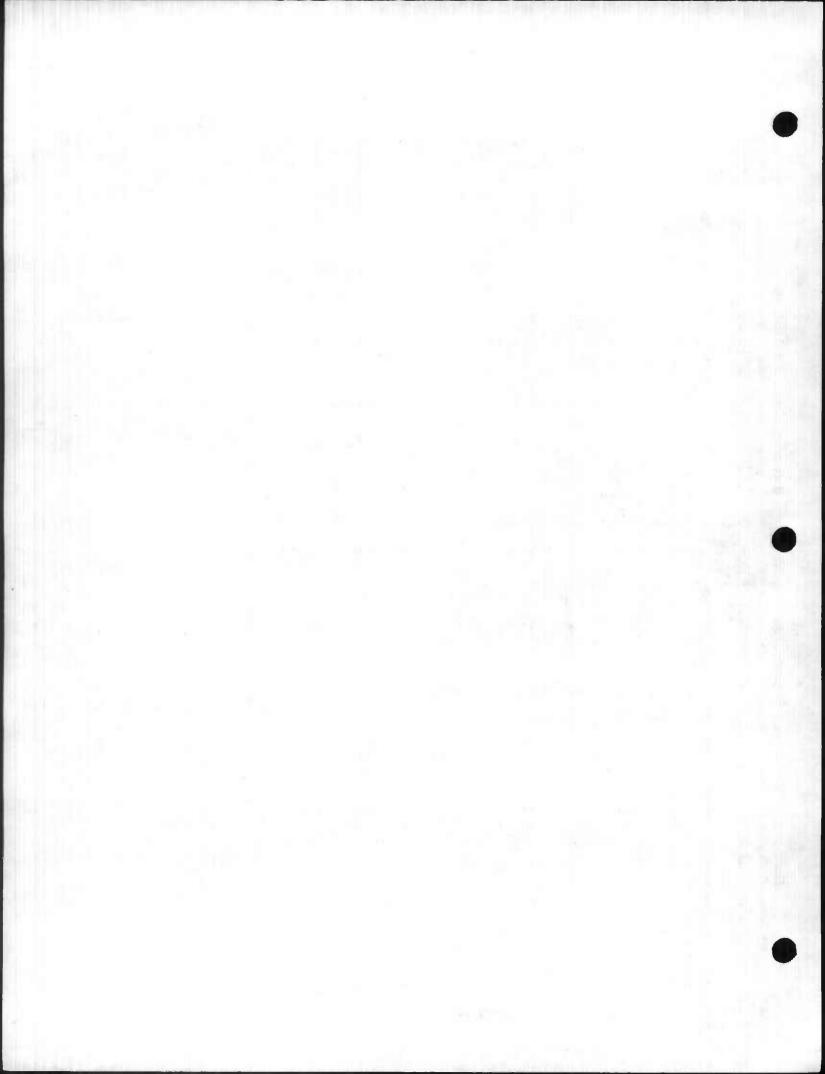


State of Maryland / Department of Health and Mental Hygiene

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				ertitica	ate of	Death			Reg. No.			- Eu
Physician	1. Decedent's Name (First, Middle, L FRANK	IRIGHT		RAY	KTE	D	2	2. Date of De Month	Day	Year	3. Time of I	Death
/Medical				0/1/				Augus		2000	6.71) PM
Examiner		1.1	OSPITA	1		0		ation of Deat	4c. County	y of Death		
5			n yrs. last birthd		der 1 Year		TIME 24 Hrs. 18		th	9 Rintho	Jace (State or	Foreign
Funeral Director		1⊠M 2□ F	63 Yrs	Month	ns Days	Hours	Min.	B. Date of Bir (Month, De October	1, 1936	Wash	lace (State or try) ington,	D. C
9	Usual Residence of Decedent									, , , ,		
able de	10a. State 10b. County		C. City, Town or							1	0d. Inside Cit	
or 28s-f	Maryland Montgome	ry	Rockvil:	-				т.				2 140
D No.	1 1/00 11-11 3 1				Zip Code				10g. Citizen of 1			
after death with the Maryla after 23e or 28e-f sho triner must be notified at Funeral Director	1420 Fallsmead W	12. Wes Decedent Eve	rin U.S. I 1		20854	lispanic Ori	igin? (Speci	ify Yes or No		ce - Americ		
har of the of th	1 Never Married 2 X Married	Armed Forces? 1 X Yes 2 No	1960-	If Yes, s	pecify Cub	an, Mexicar	n, Puerto Ri	can, etc.)		ck, Whita,		
D 24 0		If Yes, Give Year or Dates:	1991	1□ Yes	2 🔯 No	Specify:			Specif	w Whi	te	
ed within 72 ho rgiens. er then "netur 4, the Medical.	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a. De	cedent's U	sual Occup work done	oation during mos	t of working	,	16b. Kind of B	usiness/Inc	dustry	
Man Man	Elementary/Secondary (0-12)	College (1-4or 5+)			-		t of working		II C C-			
Dell'in		4	FIE	etrica	ar En	ginee:		First Middle	U.S. Go		nent	
d 2 should be the th and Mental Hy 7 is marked othe traumatic event								Wrigh		,		
Man Man	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addr	ess (Street				er, City or Town	, State, Zip	Code)	
24 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m	Susan T. Baxter/	Wife	1420) Fal:	lsmea	d Way	, Rocl	kville	, Maryl	and 2	0854	
Pages 1 a sent of He ret: If Nem rry or othe	20a. Method of Disposition		20b. Place of Di	sposition (f	Name of or other pla	ce)	1	Date g. 28,	20c. Location	- City or To	wn, State	
Page nent int iff	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Arlington					000	Arlington	n, Vir	ginia	
Separate Management In Property Inches Inche	21. Signature of Funeral Service Lice	nsee	-	22. Name	and Addre	ess of Facilit	ty Funera	al Home	/Rockvill	e. Inc		
201 2 2	VIT a	MO							kville, M			-2805
	23a. Part1. Enter the disease of con shock, or heart teilure. List on	plications that caused the	death. Do not	enter the m	node of dyir	ng, such es	cardiac or	respiratory e	rrest,		Approximate Interval Betw	Meen
Physician						-		0			Onset and D	eath
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	a. Adult	Resp	rate	my	Dis	tres:	s >	Indror	ne	20	eek
			a to (or as a con								2	010
executed in and itel-transit	Sequentially list and ditions	b. CMV	Pheu of lor as a con					_		1	2006	ers
certificate be executed ding physician and se as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Manti	THE COLUMN			- la -	00.0				1	ear
ding physicia se as the bu	Cause (Disease or injury that initieted events resulting in death) Last	C	to (or as a con			pho	Moc			1	, 3	
ding pl										1		
death ce attend ad for us		0.								1		
es that the death or igned by the attented for under by Physician	Part II. Other aignificant conditions	contributing to death but n	ot resulting in th	e underlyin	g cause giv	ven in Part I	l.	23b. Did	tobacco use co	entribute to	the cause o	! death?
ed by detac	Neutropeni	a						10	Yes 20/No	3 Pro	bably 4 U	Jnknown
The law requires that the site has been signed by the page 2 should be detached.								24a. Wes	an autopsy	24b. W	ere autopsy fi	ndings
The law require sate has been si, page 2 should Completed							44	perfe	med?	00	allable prior to mpletion of ca death?	iuse
e has								110	Yes 2□No		Yes 250/1	150
					-	26 Place	e of Death /	Check only		- "		***
Physician: The I this certificate his rall director, page 11: To Be Com		Hospital:	2 ☐ ER/Outpa	tient 3	DOA Ott	Nor-			dence 6 □Ot	ner (Specif	y)	
neral neral		28a. Date of Injury (Month, Dey Ye	28b. Tim Inju		28c. Injur				how injury occur			
endir eath. catic	2 Accident investigation			M	10	Yes 2□						
free differ of the by	3 ☐ Suicide 6 ☐ Could not to determined		At home, ferm, Specify)	street, fect	tory, office		28	f. Location (City or To	Street and Numi wn, State)	ber or Rura	il Route Numl) <i>01</i> ',
oral or l	CON CONTROL OF THE PARTY OF											
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa-	nyalclan: To the best of m miner: On the basis of exi and manner stated	amination and/or	eath occum rinvestigati	ed at the tir ion, in my d	me, date an opinion, dea	nd place, an oth occurred	d due to the l at the time,	cause(s) and m date and place,	anner as s and due to	taled. the cause(s)	
o the o the omple	29b. Signeture and title of certifier				29c. Licens				29d. Date signe	ed (Month,	Day, Year)	
1.1		Donindra	p M.	D.	2	02	13		Augu			00
204												
	30. Name and address of person who NIKU PAMA GOVINDR	AJ, Johns Ho	pkins Ho	ospito	11,6	00 1	1.Wol	fe Str	reet, Bo	altim	ore,MD	-2128
State	31. Date filed (Month, Day, Year) AUG 11 20	32. Begistrar's	Signature									
Registrar	HOP 1 1 50	100 Siner	· 19.	de	rocks	/						

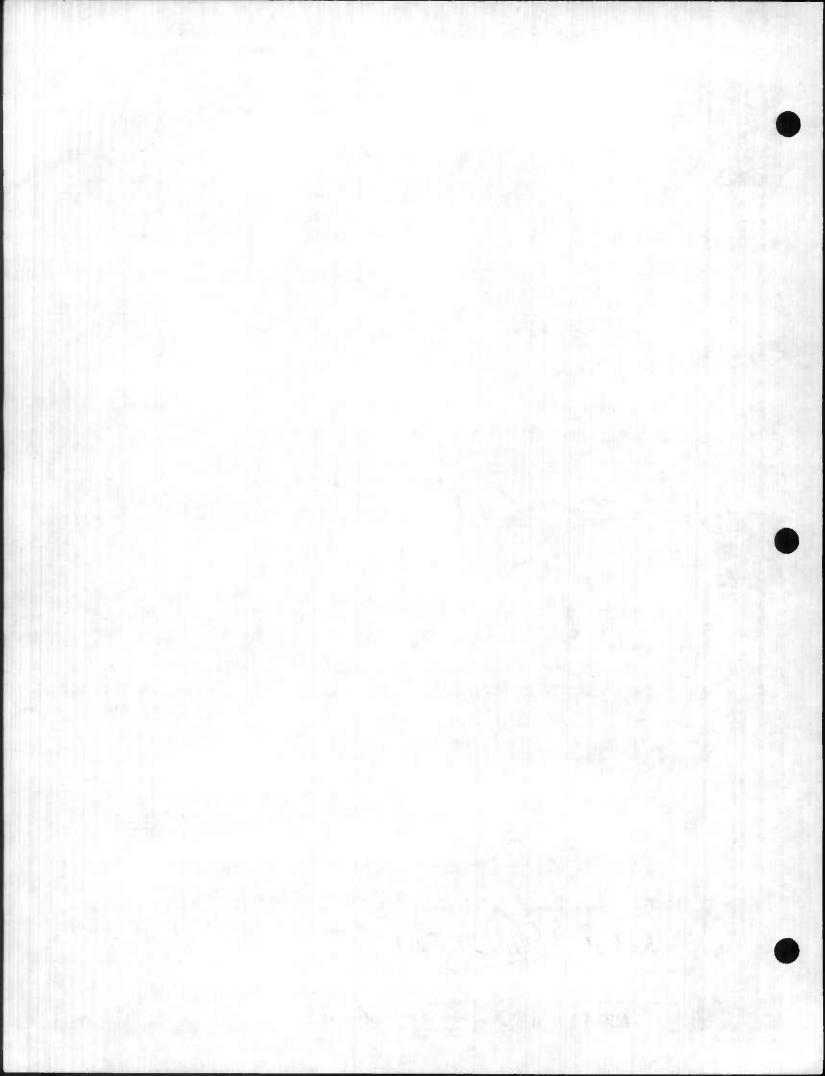
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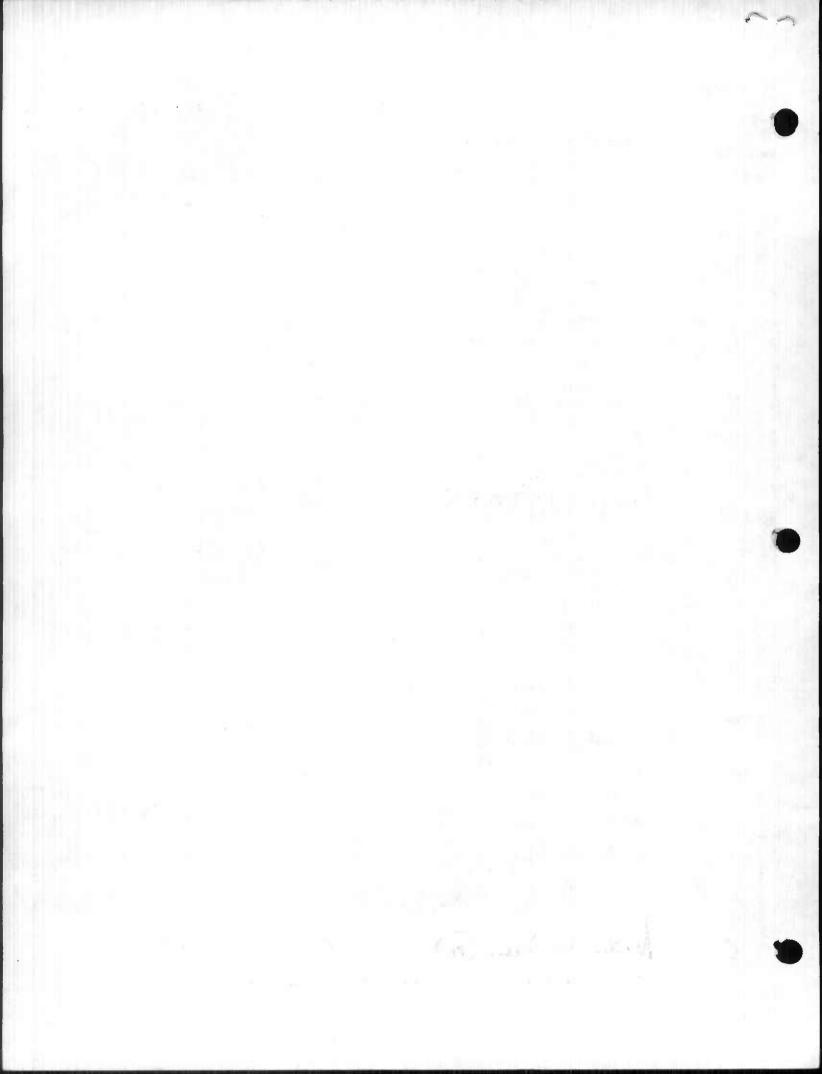
					Olulo Ol	maryiai	(Certific	cate of	Death	,,,,,	Reg. No.	00	26693
		_	. Decedent's Name	e (First, Middle, La	st)					ALL YOU	2. Date of De Month	Dey	Year	3. Time of Death
4	Physician /Medical		ildred L	orraine H	Bohner						August	9, 2000		8:45 am
	Examiner			f not Institution, give		ber)				4b. City, Town, or		h 4c. County	of Death	
				mpanion 1						Silver S	pring	Montg	omer	у
	Funeral		. Sociel Security N	1	OM 20 F	. Age (In yrs. 74			nder 1 Year hths Days	Hours Min.	(Month, Da	th ly, Year)		place (State or Foreign ntry)
	Director	- Inches	78-28-76			/4		10.			May 28	, 1926	Virg	inia
	Pag ga	-	Oa. State	10b. County	- 1414-14	10c. Ci	ty, Town	or Location						10d. Inside City Limits
	Man Man	M	faryland	Montgome	ery	Sil	ver	Sprin	g					1 ☐ Yes 2X No
	or 28s-f. be notified	1	0e. Street and Nun			Note A			I. Zip Code			10g. Citizen of	What Cou	ntry?
	8 8 2	5 1	1112 Bra	ntford Av	renue			2	0904			USA		
	her death r hams 23 inst. must Funeral	1	1. Maritel Stetus		12. Was Deced Armed Ford	lent Ever in U	,S.	13. Was E	ecadent of h	lispanic Origin? (S an, Mexicen, Puerl	pecify Yes or No o Rican, etc.))- 14. Rad Bla	ck, White,	can Indien, etc.
Maryland 21215-0020	Br. or	-	1 Never Marris	ed 2 Married 4 Divorced	1 Tes 2 If Yes, Give Year or Dat	No No			es 2 No			Specif		hite
5-0	natur natur dical		(Spec	15. Decedent's Ed	fucetion de completed)		1	(Give kind o	Usual Occup	during most of wor	rking	16b. Kind of B	usiness/in	dustry
121	ed within ygiene. wer than it. the Me		Elementary/Secon		College (1-	4or 5+)		life. DO NO	OT use retire	d)				
12			7 Fether's Name /	(First, Middle, Last)			Ban	k Tel	ler	18. Mother's Ner	na /First Middle	Banking		
an	o Be	1										, maigar Sumai	110)	
7	and Ma and Ma is mark summation		lalter Kn	OCC ame/Relationship (Type, Print)		19b.	Mailing Ade	dress (Street	Mildred and Number or Ru		er. City or Town	State. Zii	p Code)
Ma	and 2 is mailth ar na 27 is er trau			raine Bur		uchter								
e,	The House		Oa. Method of Disp	position		20b. i	Place of	Disposition	(Name of or other pla		Date	20c. Location	City or T	own, State
E	Page nt: #			XCremation 3 5 Other (Specify		late					8/9/00	Alexand	lria.	VA
altimore,	A Indiana	1	21. Signature of Fu	neral Service Licer	1500	/ 1	11	22. Nam	ne end Addre	ess of Facility				
00	88288		1/	# 1	1/	7				Collins				g, MD 20901
		1	23a Fart1. Enter the	ne disease, or octili rt failure. List only	plic inions that ce	used the deel	h. Do no	ot enter the	mode of dyl	ng, such as cerdie	c or respiretory e	orrest,	brit	Approximate Interval Between
	Physician -	1	3.10011, 0.1100.	Transfer English		ort 11710.								Onset and Death
	/Medical Examiner		mmediate Cause (Final n	a Parki:	nson's	Dis	ease						
			resulting in death)		4.		-	onsequence	e of):					
	Pin in				b	L. Out				200			-	
	filcate be executed g physician end as the burial-transit		Sequentially list cor fany, leading to im cause. Enter Unde Cause (Disease or hat initiated events	nditions, imediate		Due to (or as a co	onsequence	of):					
68760,	Siciar Buri	,	cause. Enter Under Cause (Disease or hat initiated events	injury	C	Due to fe								
89	2 04		esulting In death) L	ast		D) of euc	n as a cc	onsequence	01).					
Box	death certing a stending of for use is				d									
	0 0 %	F	art II. Other eignifi	icant conditions of	ontributing to dea	th but not res	ulting in	the underly	ing ceuse gi	ven in Part I.	23b. Dld	tobacco use co	entribute 1	to the cause of death?
P.0	law requires that the de es been signed by the a of should be detached nolleted by Physic		A 4-1-	1		,	D.				10	Yes 20 No	3 Pro	bebly 4 Unknown
Ś	be d		Atnerosc.	lerotic (ardiova.	scular	Dis	ease						
ord	The law requir page 2 should Completed										24e. Was	en autopsy ormed?	(8)	Vere autopsy findings vailable prior to ompletion of cause
ec	hes b					HT X							of	f death?
F	Com									Tuk See L	10	Yes 2X No	1	☐ Yes 2💢 No
of Vital Record	Physician: The this certificate ral director, page Co.: To Be Co.		25. Was case referr examiner?		Hospital:				Ott		ath (Check only	_		
o	T T		1 ☐ Yes 2 [X]		1 In		28b. Ti	patient 3[J DOA	4EJ Nursing r	lome 5 Resi	how injury occu		ify)
O	After fune		1 Natural	5 Pending Investigation	(Month	Day Year)		jury	28c. Inju Wo	rk?` Yes 2□No	200. 2000 20	now injury cood		
Division	after death. Director: After I by the fune of in by the fune certification.		2 Accident 3 Suicide	6 Could not be	28e. Place o	of Injury - At h	ome, fan	m, street, fa	actory, office				ber or Rui	ral Route Number,
á	tal or Attending P is after death. at Director: After led in by the funer Certification:		4 Homicide	30,0,,,,,,,	building	g, etc. (Specia	y)				City or To	wn, State)		
	To the Hospital o within 24 hours at To the Funeral Di completely filled li	2	29a. Certifier (Check only	1X Certifying Ph 2☐ Medical Exam						me, date and place				
	the Hospit in 24 hour the Funer iplately fill		one)		and manne		nion and	ror investig			med at the time,			
	With To	2	9b. Signature and	to the state of certifier	4	1	0	0	29c. Licen:	se number		29d. Pate sign	od (Month	Day, Year)
	1		May	reer 11	Qua	4	M	U	D 00	55522		8 N	00	
				ess of person who	•									
			Robert H	. Gerard,		10 Con		icut	Ave.,	Kensingt	on, MD	20895		
	State Registrar	ľ		UG 11 2		eners signi		4.	land.	w				

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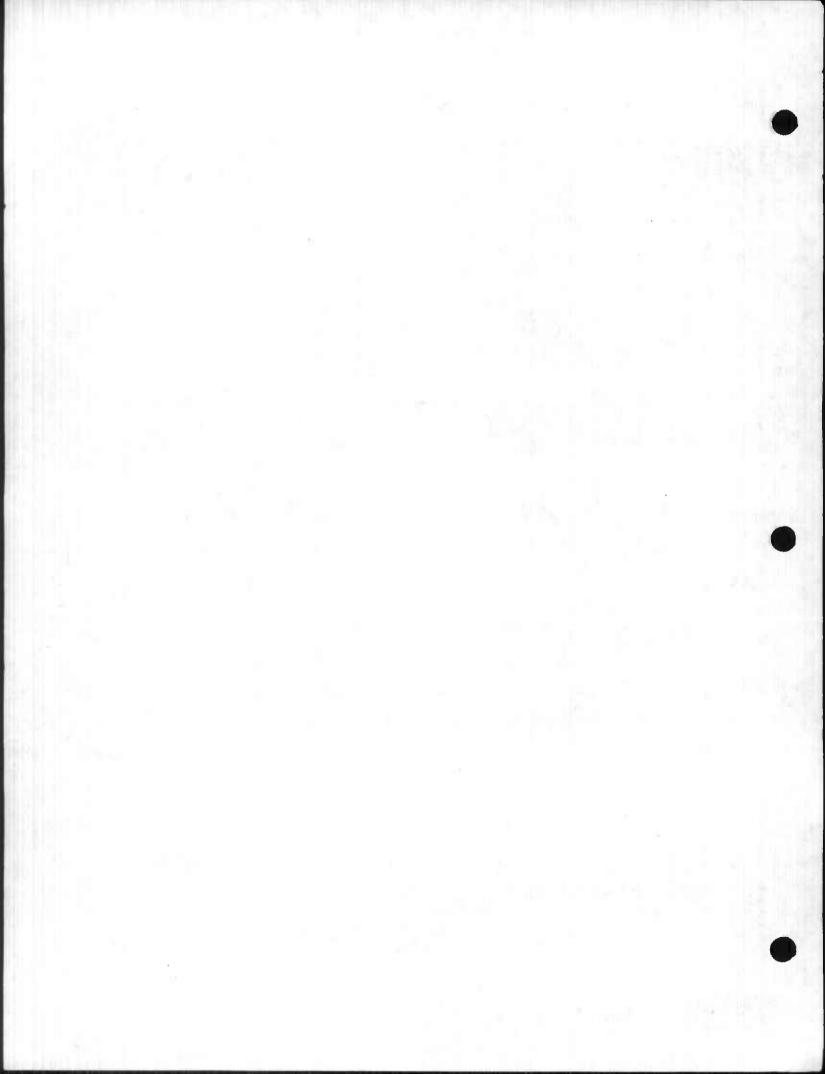
State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificat	te of	Death	, , , , , , , , , , , , , , , , , , ,	Reg. No.	0 26	0694
Physicia	an	Decedant's Nama (First, Midd							2. Data of D Month	aeth Day	Yaar	3. Time of Daath
/Medic		Harold	Loyd		Bra	agg			Augu	st 1, 20	000	11:25 P
Examin	er	4a. Fecility Nama (If not institution						4b. City, Town, or			ty of Deeth	
		Randolph Hill				lá l lada	V.	Wheat			tgomery	
Funeral Director		5. Social Security Number 233-52-9991	6. Sex 1 M 2 □ F	7. Aga (In yr	s. lest birthday) Yrs.	Months	Deys	if Under 24 Hr Hours Mir	s. 8. Data of B (Month, D OCt.	irth 24, 1935	9. Birthpia Country West	ce (Stata or Foreign Virgini
ž		Usuel Rasidanca of Decedant 10a. Stata 10b. County	,	10c. (City, Town or Lo	ocation					100	d. Insida City Limits
28a-f show	0	MD Monts	gomery		ilver S		Or.				100	1 ☐ Yes 2 ☐ No
7 28a-f	rec	10e. Street end Numbar	, omer y		TIVCI	10f. Zip				10g. Citizan of	What Country	4.5
ms 23a or 28a-f show	<u>[</u>	3403 Robey Ter	race Ar	t. #30	4		0904			USA		
0 10	by Funeral Director	11. Maritel Status 1 Naver Married 2 Mer 3 Widowed 4 Divorces	12. Was Dec Armad For ried 1X Yes	edant Evar in orces? 2 \(\subseteq \text{No} \)	U,S. 13.	Was Dece If Yas, spe	dant of I	dispanic Origin? (an, Mexican, Pua Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Ra	ace - Amaricar ack, Whita, at	c.
"natural",	ted		nt's Education		16a. Deca	dant's Usu	al Occup	petion		16b. Kind of E	Businass/Indu	
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d oth	Be	17. Fether's Nema (First, Middla,						18. Mothar's Ne	ema (First, Middle	e, Meidan Suma	ma)	
Men	2	Azel Loyd Brag	gg					Allie	Grace R	ichmond		
is marked of		19a. Informant's Name/Raiations						and Numbar or F				oda)
m 27		Kendra Johnsto	on	1001					Princet	-		
nent of h		20a. Method of Disposition 1 ☐XBuriai 2 ☐ Cramation	3 Ramoval from		Place of Dispo camatery, crei				Data	20c. Location		
tant		4 Donetion 5 Othar (5	pacify)	S	unset N				8/5/00		Ley, WV	
Department of Health and Mentel Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, tra life once		21. Signature of Funeral Service	· LLCC	0 Obs	Q			ss of Facility Itan Fun e Street				310
	-	23a. Fart1. Enter the disease, of shock, or heart failure. List	complications that o	aused the des	Do not ent	tar tha mod	la of dyi	ng, such as cardle	ac or respiretory	errast,	A	pproximete ntervel Between
ysician fledical aminer		Immadieta Cause (Final disaasa or condition	86.	umonia							C	Weeks
	iner	rasulting in daeth)	Met	Dua to astati	(or as a consec C Lung	quanca of): Cance	r					Year
	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	S	Dua to	(or as a consec	quance of):						
ing physic e es the b	Medical	thet initiated avents rasulting in death) Last	C	Due to	or as a conseq	juance of):						
thend or us	Physician/		d									
the a	ysic	Part II. Other elgnificant condition	ons contributing to de	eath but not re	sulting in tha u	ndariying c	eusa giv	an in Part I.	23b. Dld	tobacco use co	ontribute to ti	he cause of death?
	by Ph	Chronic Obst	ructive L	ung Di	sease				1 🗷	Yes 2□ No	3 Probal	bly 4 Unknown
	Completed b	Respiratory	Insuffici	ency			, TI		24a. Was	s an eutopsy ormed?	availa	e eutopsy findings able prior to eletion of causa eth?
ate he	0								1 🗆	Yas 2 No	101	fas 2□ No
	Be	25. Was casa raferred to madica axaminar?	4					26. Plece of Da	ath (Check only	one)		
0 0	2	1 ☐ Yas 2 ☐XNo	Hospital: 1 □ I	npatiant 2[☐ ER/Outpetian	nt 3□ DC	Oth Oth	ar: 4⊠ Nursing I	Homa 5□Ras	idanca 6 🗆 Ot	har (Specify)	
ctor: After thing the funeral	atlon:	27. Mannar of Daath 1 ☑Natural 5 ☐ Pendir 2 ☐ Accident Invasti		of Injury th, Day Yeer)	28b. Tima of injury	M 2	l8c. Injur Wor 1 □	yat k? Yas 2 □ No	28d. Dascribe	how injury occu	rred	
ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicida detarm	ined 288. Place	of Injury - At I	noma, ferm, str ify)	aat, factory	, offica		28f. Location City or To	(Straat and Num wn, Stata)	ber or Rural F	Routa Number,
Funer tely fill	edical	29a. Cartifiar 1 ☐ Cartifyin (Check only one)	g Physician: To tha Examiner: On tha ba and mann	bast of my kn asis of axamin ar stated.	owladge, daeth ation and/or inv	occurred vastigation,	at the tir , in my o	na, data and place plnion, daath occ	e, end dua to tha urred at tha tima,	ceuse(s) and m data and place,	enner es steta and due to th	ad. ne causa(s)
To the comple	-	29b. Signatura and titla of certifia		7		290	. Licans	e numbar		29d. Data signe	ed (Month, Da	y, Year)
5		30. Nema and eddress of person	- ha	Al death fin) m 23e) (Tune	Print\	D()8944		August	2, 200	00
		Martin Sharg	el, MD 3	20 Far	ragut		e k	Censingto	on, MD			
State	е	31. Data filad (Month, Day, Yaar)		gistrar's Sign	lature 4	1	- 11	,				



State of Maryland / Department of Health and Mental Hygiene 00 26695

				Cei	tificate of	Death	R	eg. No.	2.0033
		1. Decedent's Neme (First, Middle,	Lest)				2. Deta of Dee Month	th Dey Yeer	3. Time of Death
(e)	Physician /Medical	Joseph B1	aine Brenne	man			August	8 2000	
	Examiner	4a Facility Neme (If not institution,	give street end number)			4b. City, Town, or L	ocation of Death	4c. County of Dec	eth
		Washington Adven	tist Hospital			Takoma Pa	rk	Montgom	ery
	Funeral		ACIAL OCIE	yrs. lest birthdey)	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey	Year) 9. Bi	irthplece (State or Foreign Country)
п	Director	215-26-9394	1≅M 2□F 7(Yrs.	10.74		Dec. 27	, 1929 Man	ryland
	2 .	Usuel Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cetion				10d. Inside City Limits
	aryta asho		Company of the compan						t ☐ Yes 212 No
	or 28e-f	Maryland Montgo	nery	Silver S _I	_			0g. Citizen of What C	
			1		10f. Zip Code	,			ountry?
	r Herre 23 Amer.must Funeral	1128 Tanley Roa	12. Wes Decedant Ever	in 11 6 12 1	2090		posity Vac or No.	USA 14. Race - Am	sericen Indien
	the diameter of	11. Merital Status 1 ☐ Never Merried 2 ☑ Marrie	Armed Forces?	10,5.	f Yas, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bleck, Wh	
020	ors of		If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
15-0020			The second second	16a, Deced	fant's Usuel Occup	pation		16b. Kind of Busines	s/Industry
115	ed within 72 ho ygiere. wr than "natur it, the Medical. Completed	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of work	ring		
212	The Best of the Be	Elementery/Secondery (0-12)	College (1-4or 5+) +4	C	ontracto	r		Buildin	g
2	and Hyger and American Be C	17. Father's Neme (First, Middle, La	est)			18. Mother's Nem	e (First, Middle,	Maiden Sumeme)	
/lar	Abenta A Abenta A Abenta Abenta A Abenta Abe	Clark Brenneman				Sarah B	ittinger		
an	dans.	19e. Informent's Neme/Reletionshi	o (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number	r, City or Town, State,	Zip Code)
Σ	and a	Adella Brenneman	/ Wife	1128	Tanley R	oad, Silv	er Sprin	ng, Maryla	nd 20904
ore	T Be th	20e. Method of Disposition		Ob. Piece of Dispo	sition (Neme of netory or other ple	ce)	Dete	20c. Location - City of	r Town, Stete
mor	Page	1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Othar (Spe		Gate of H	leaven Ce	metery 08	/12/00 8	Silver Spr	ing, Maryland
3	Part S	21. Signetura of Funarel Service Li		22	. Name and Addre	ss of Facility Hin	es-Rinal	ldi Funera	1 Home
n	SELES	1111)			Hampshir ring, Mar		20904	
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	Physician	shock, or heart fellure. Listor							tntervel Between Onsat and Death
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	certificate be executed ding physician and use as the buriat-transit	Sequentially list conditions,	Due Due	to (or es a consec	quenca of):	2-			0 00 00
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98/90	ficate be physicials the burners edical	thet initieted events resulting in death) Last	Due	to (or es e conseq		0.1	0 0 -1		154-10
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g	ath or it								1
j	the day the ached	Pert II. Other eignificant condition		t resulting in the u	nderlying cause gi	ven in Pert I.			te to the cause of death?
7	res that the de signed by the a i be detached i by Physic		TES ME	2417	US		101	ea 211146 31	Probably 4 Unknown
ds	requires that seen signed b should be dete						24a, Was a	an autoosy 24t	o. Were autopsy findings
ecords,	been si should						perfor	med?	available prior to completion of cause
ř	has pe 2							-/	of death?
	icien: The liceting rector, page						1DY	as 2 1 No	1 Yes 2 No
Vital	Physician: this certific ral director, TO Be (25. Wes case raferred to medicat examiner?	Hospitel:		Ot	26. Plece of Dee			1987
0	Physic rithis caral direction To		1 1 Impatient 28a. Dete of Injury	2 ER/Outpatier	I 3LI DOA	4 LI Nursing H		enca 6 Other (Sp ow injury occurred	necity)
DIVISION	ding Ph After th funeral	1 ☑Neturel 5 ☐ Panding 2 ☐ Accident investiga	(Month, Dey Ye	ar) tnjury	Wo	rk?]Yes 2 ☐ No			
<u>s</u>	tal or Attending P rs aftar death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could no determin	t be 28e. Plece of Injury -	At home, ferm, str	reet, fectory, office		28f. Location (S	treet end Number or	Rurel Route Number,
5	aftar Dire din t	4 Homicide	building, elc. (S	pecify)			City or Tow	n, Stete)	
	To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier 1 Certifying	Physician: To the best of my	knowledge, deeth	occurred et the ti	ime, date end plece,	end due to the c	ause(s) and menner	es stated.
	in 24 hou he Funer pletely fill edical	(Check only 2 Medical E)	taminer: On the basis of exa and manner stated.	minetion end/or in	vestigation, in my	opinion, deeth occur	red et the time, o	iete end placa, and d	ua to the ceuse(s)
	within 2 To the comple	29b. Signetura end title of certifier	· ALL	1 11	29c. Lican	sa number	7	29d. Data signed (Mo	nth, Day, Year)
		1 Vi Sir	加加	dilhy	1 0	19,49		8/8/200	0
	10	30. Neme and eddress of person w	no completed cause of death	(Item 23a) (Type,	Printho Oo	Die Mi	1150	-1001+	000.77
		V. SING H	17209A	HANO,	VER MY	KKWHY	GNED	117 5 51	To 110
	State	31. Dete filed (Month, Day, Year)	32. Degistrar's S	Signeture	1	,			
	Registrar	AUG 112	non Denew	D.	souks	/			



State of Maryland / Department of Health and Mental Hygiene 26696 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month BROWN August 13 2000 8:30 PM

Physician /Medical Examiner

ELEANOR

that the death certificete be executed physician and s the bunal-trans for use as P.O. signed by the a Records, director, this

4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore City Sinai Hospital 8. Dete of Birth (Month, Dey, Year) Feb. 7, 1924 7. Aga (In yrs. last birthday) If Under 1 Year It Under 24 Hrs. 5. Social Security Number Birthpiece (Stata or Foraign Country) **Funeral** Days 1□M XXF Hours Months Yrs 76 Massachusetts Director 579-20-7244 Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Prince George's Laurel 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 20707 USA 7908 Brooklyn Bridge Road death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bieck, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home other 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumema) Be Peges 1 and 2 should be nent of Health end Mental int: If item 27 is marked or Marie Josephine Kirk Peter Edward Daken 19e. Informent's Neme/Rejetionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9445 Turnberry Drive, Potomac, MD 20854 Patricia Ferrill/Daughter other 1 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify) 6 permit. Pege Department of Important: If any Injury or once. St. Mary's Cemetery 8/17/00 Laurel, Maryland 22. Name end Address of Fecility Donaldson Funeral Home, P.A. 21. Signatili MO0773 313 Talbott Avenue, Laurel, MD 20707 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. List only one cause on each line. Approximete Intervei Between Onsat and Deeth **Physician** /Medical Immediate Cause (Final TACHY CARDIA 5MTS disease or condition resulting in death) Examiner Examiner CORONARY ARTERY Sequentially list conditions, if eny, leeding to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence ot) Physician/Medical Dua to (or as a consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 1 No 3 Probably 4 Unknown HYPERTENSION, ABDOMINAL HORTIC ANDVEYSM þ 24b. Were autopsy tindings eveileble prior to Completed 24e. Wes en eutopsy performed? RESECTION, CAROTID DISPASE, CHRONIC OBSTRUCTIVE completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No DISEASE 25. Wes cese reterred to medical exeminer? Division of Vital Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 W Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation or Attendation of the design o 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, streat, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and menner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Yaer) MA 0 22755 8.14.2000 10 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) LAJER MO 20707; CHESTINE DELIMAMO 1350 VAN ANSEN RD

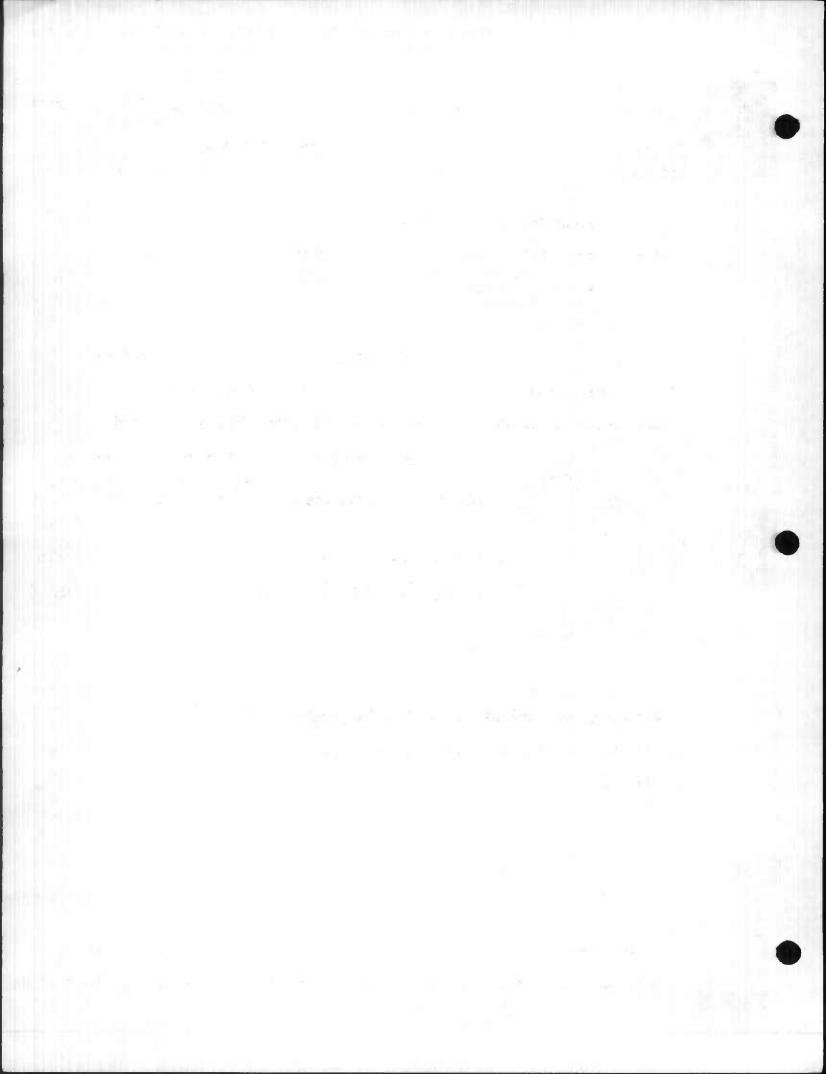
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32 Registrer's Signature

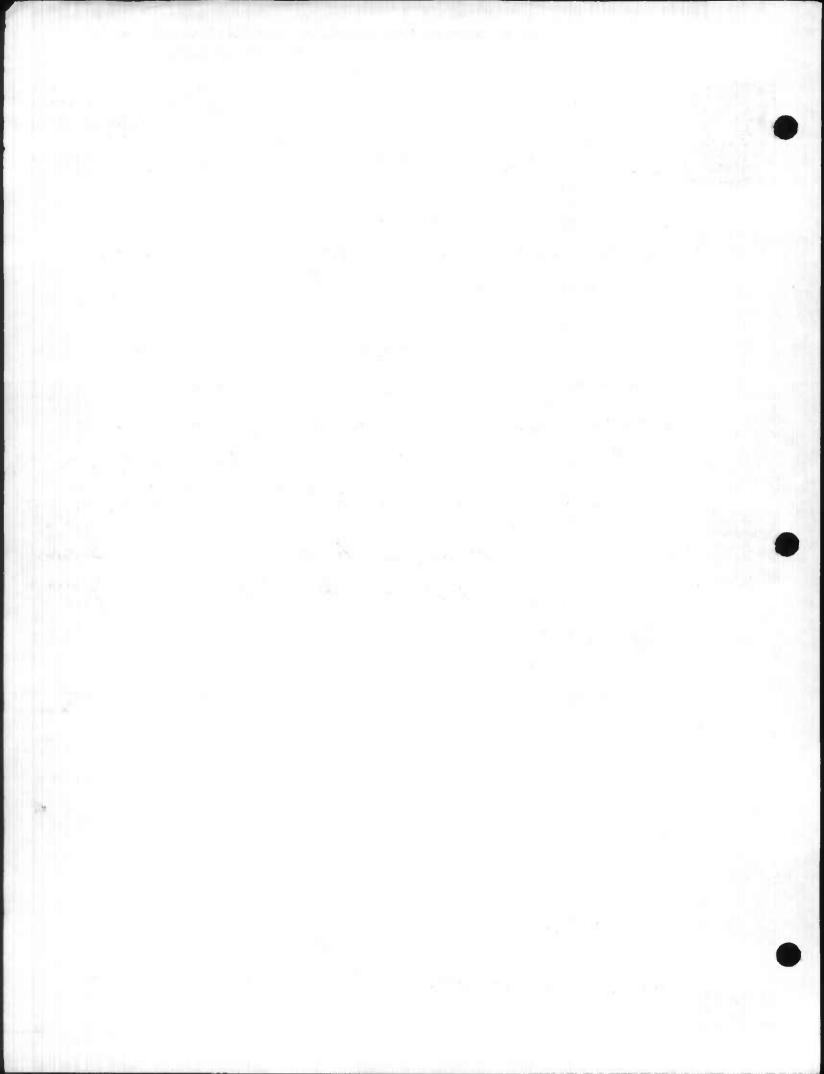
State Registrar 31. Dete tiled (Month, Day, Year)

AUG 1 5 2000



State of Maryland / Department of Health and Mental Hygiene

Social Security Number 115-24-0344 Suel Residence of Decedent 0e. Stete 10b. Count Maryland How 0e. Street and Number 7070 Cradl 1. Maritel Status t Never Married 2\(\tilde{D}\) Ma 3 \(\tilde{W}\) Widowed 4 \(\tilde{D}\) Divorce (Specify only high Elementary/Secondary (0-12) 7. Fether's Neme (First, Middle Gustav Torgu 19e. Informent's Name/Relation	an Beckle on, give street end no ock Way 6. Sex 1 M 2 F ard erock Way 12. Wes Dec Amed F 1 Yes, G Yeer or 1 nt's Education est grade completed, College (# 419 7. Age (In) 10c. # 41 cedent Ever to orces? 22 No ive	n U,S. 13	Months Location Dia 10f. Zi 2 Was Dece If Yes, spe	r 1 Year Deys	Columb If Under 24 H Hours M	rs. 8 Date of B	th 4c. County HC	9. Birthpl Count New	•	
e. Fecility Neme (If not institution 7070 Cradler 7070 Cradler 115-24-0344 Jouel Residence of Decedent 10b. Count 10b. Count 10b. Count 10b. Count 10b. Count 10b. Cradl 10b. C	erock Way 6. Sex 1 M 2 F ard erock Way 12. Wes Dec Armed F rried I 1 Yes, G Yeer or I nt's Education est grade completed; Last)	# 419 7. Age (In) 10c. # 41 cedent Ever to orces? 22 No ive	85 Yrs. City, Town or I Columb 9 n U.S. 13	Months Location Dia 10f. Zi 2 Was Dece If Yes, spe	r 1 Year Deys	Columb If Under 24 H Hours M	ia	th 4c. County HC irth ay, Year) 10g. Citizen of	of Deeth ward 9. Birthpl Count New 10	lece (State or Foreign YOTK 0d. Inside City Limits 1 Yes 2 No try?	
Social Security Number 115-24-0344 Javel Residence of Decedent Oe. Stete 10b. Count Maryland How Oe. Street and Number 7070 Cradl 1. Maritel Status t Never Married 2\(\tilde{D}\) Ma 3 \(\tilde{W}\) Widowed 4 \(\tilde{D}\) brorce (Specify only high Elementary/Secondary (0-12) 7. Fether's Neme (First, Middle Gustav Torgu 19e. Informent's Name/Relation	6. Sex 1 M 2 F y ard erock Way 12. Wes Dec Armed F 1 Yes, G y Yeer or 1 nt's Education est grade completed, College (7. Age (In) 10c. #41 cedent Ever iorces? 2 No ive	85 Yrs. City, Town or I Columb 9 n U.S. 13	Months Location Dia 10f. Zi 2 Was Dece If Yes, spe	Deys Code 1045	if Under 24 H Hours M	rs. 8 Date of B	orth (1914) 10, 10g. Citizen of	9. Birthpi New	York Od. Inside City Limits 1 □ Yes 2 No	
Justin Residence of Decedent Oe. Stete 10b. Count Maryland How Oe. Street and Number 7070 Cradl 1. Maritel Status t Never Married 20 Ma 3 Widowed 4 Divorce (Specify only high Elementary/Secondary (0-12) 7. Fether's Neme (First, Middle Gustav Torgu	ard erock Way ard 12. Wes Dec Armed F 1	#41 cedent Ever i orces? 2 No ive	85 Yrs. City, Town or I Columb 9 n U.S. 13	Months Location Dia 10f. Zi 2 Was Dece If Yes, spe	Deys Code 1045	Hours M	rs. 8. Date of B in. Aug. 3	ay, Year) 0 , 1914	New 10	York Od. Inside City Limits 1 Yes 2 No	
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(Specify only high Elementary/Secondary (0-12) 7. Fether's Neme (First, Middle Gustav Torgu 19e. Informent's Name/Relation	College (16e. Dec		as Decedent of Hispenic Origin? (Specify Yes or N Yes, specify Cuben, Mexicen, Puerto Rican, etc.) ☐ Yes 2 ☑ No Specify:			Bleck, White, etc. Specify: white			
7. Fether's Neme (First, Middle Gustav Torgu 19e. Informent's Name/Relation	, Last)	(1-4or 5+)	(Giv	edent's Usu	ei Occup	petion during most of v	vorking	16b. Kind of B	usiness/Ind	lustry	
Gustav Torgu 19e. Informent's Name/Relation				memak		od)		Own H	iome		
	17. Fether's Neme (First, Middle, Last) Gustav Torgusen					18. Mother's N			, Maiden Sumame) 2n		
John Beckley /	ship (Type, Print)		19b. Mei	iling Addres	s (Street	t and Number or	Rurel Route Num	ber, City or Town,	State, Zip	Code)	
				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				21045			
			cemetery, cremetory or other pi			Aug.16,					
		-			_	ess of Fecility	2000	Catons	ville	MD.	
1	1	4/0									
23a. Pert1. Enter the diseese, of shock, or heart feilure. Lis	or complications that tonly one cause on			nter the mo	de of dyl	ng, such es card	liac or respiretory	errest,	Try	Approximete Intervel Between	
										Onset end Deeth	
disease or condition	θ	11/2	Higus	Wf	47	つかけん	u 1			Jewleler YEars	
		0001	o (or as a cons	tuee	14	earl 1	Carlens		1	Years	
Sequentially list conditions,	6.	Due	o (or es e cons	equence of)					1	/	
Jause (Disease or Injury	c	Dunt	. (22 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2								
esulting in deeth) Lest		Due to	o (or es e conse	equence or):							
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ert II. Other elgnificant condit	ons contributing to d	leath but not	resulting in the	underlying	ceuse gi	ven in Pert I.				\ .	
							_ 10	Yes 2∐No	3 ☐ Prob	bably 400 Unknown	
							24e. We	performed?		ere autopsy findings Bilable prior to	
									of o	mpletion of cause deeth?	
S Man constraint to madia									1	Yes 2□No	
exeminer? 1 Yes 2 No	Hospital:	Inpatient	2 ☐ ER/Outpeti	ent 3□ D	OA OII	her:			er (Specify	<i>,</i>)	
≦ Suicide 6 Could not b		28e. Dete of Injury (Month, Day Year) 28b. Time of Injury						28d. Describe how injury occurred			
					M 1 Yes 2 No			on /Street and Number or Dural Doute Number			
		building, etc. (Specify)					City or Town, Stete)				
	Examiner: On the b	pasis of exen	knowledge, dee ninetion end/or i	eth occurred investigetion	et the ti	me, dete end ple opinion, deeth oc	ce, end due to the curred et the time	e ceuse(s) and m o, dete end place,	anner as st and due to	eted. the cause(s)	
29b. Signeture end title of certifier				29c. License number D2285C			29d. Date signed (Month, Day, Year) Quescielle, 200c				
		se of deeth	Item 23e) (Type	e, Print)	226 1	- N	(1	had	2/01	11	
		Registrer's S	inneture	4 /67/	17/5	-	1 Columb	4 . 7	<104	7	
				1							
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State of Maryland / Department of Health and Mental Hygiene 26698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Alabama 8. Dete of Birth (Month, Day, Year) Nov 30, 1943 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 12 M 2 F 426-84-0331 Yrs. 56 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28s-f ahow the Medical Examiner must be notified at MD Prince George's Capitol Heights 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 Karen Blvd 20743 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "natural", or free any Injury or other treumstic event, the pages. 1 Never Married 2 Married Black 1 Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 Margretta Smith Samuel Chaney Sr 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Tina Lee-Daughter 2818 Viceroy Avenue District Heights MD 20c. Location - City or Town, Stete 20b. Place of Disposition (Neme of 20a. Method of Disposition Dete 1 Burial 2 □ Cremetion 3 □ Removel from State Ft. Lincoln Cemetery 8-9-00 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fecility J.B. Jenkins Funeral Home Ce 0 7474 Landover Rd. Landover MD 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Ogset end Death **Physician** tmmediete Cause (Final disease or condition resulting in death) /Medical Examiner Examine that the death certificate be executed physician and s the burlei-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Box 68760. Physician/Medical that initiated events resulting in death) Last for use as 188 detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. been signed by t should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed has page 1 Yes 2 No 1 Yes certificata Division of Vital Be 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After at or Attendenth. Attending 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation in according to the cause of edical 29a. Certifier er: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and manner stated. 29b. Signature and title of certified 29d, Date signed (Month, Day 3 Registrer's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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20. Method of Disposition (Name of Cementors)	200	19a. Informent's Neme/Relationship (Type, Print)		19b. Meiling Add	ress (Street	and Number or R	r or Rural Route Number, City or Town, State, Zip Code)			
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George P. Kalas Funeral Home, P. A. 6160 Oxon Hill Rd. Oxon hill, Md. 20745 Approximate Approx	in the			Ced				10/2000	Suitlan	nd, Md.	
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29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Signature and title of certifier 29e. Signature and title of certifier 29d. Date signed (Month, Day, Year)	e fune	1/3 Naturat 5 ☐ Pending investigatio	n		tnjury M	10	_				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Danie	milado	~		Do	5095	9.	01-	110	1
T/ 1 / 1 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4)	30. Name and address of person who	completed cause of o	leath (Item 2	3a) (Type, Print)				81	1100	
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 26700 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8:22 PM 2000 ROMA EPPLEY CATE AUGUST Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince Georges 12209 Malin Lane Bowie H Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 908 5. Social Security Number 9. Birthplaca (State or Foreign Country) Maryland 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2₩F Months 91 Yrs. 578-76-0252 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yas 2 ☑ No Directo Maryland Prince Georges Bowie 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? munt be n 12209 Malin Lane U.S.A. 20715 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ᡚ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. or Harris 11. Marital Status 72 hours after 1 Naver Married 2 Merried Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Accounting Firm Payroll Auditer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter D. Mac Ewen Grace Mildred Eppley Turked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 a mont of Health an ant: If Nem 27 is Robert Louis Cate / Son 12209 Malin Lane Bowie, MD 20715 20b. Place of Disposition (Name of camatery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Ramoval from State Ft. Lincoln Cemetery August 8,2000 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licenses CONTRACTOR OF THE PARTY OF THE MISW 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part1. Enter the disease, of complications that caused in eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tr Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaese or condition resulting in death) /Medical Hemorrhage Examiner Due to (or as a consequence of): Physician/Medical Examiner Multiple Gastric Ulcers use as the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) for Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Ischemia heart disease þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed Hypertension completion of cause of death? 1 ☐ Yes XXNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Medical Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 XX Natural 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation after death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicida 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) yd ui bellii 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License numbe

The law requires that the deeth certificate be executed Box 68760. P.O. Records, Division of Vital To the Hospital or Attending Physician: to the Funerel C

Baltimore, Maryland 21215-0020

State Registrar

Paul V. Beals, M.D. 31. Date filed (Month, Day, Year) NIG 0 8 2000

32. Registrar's Signature

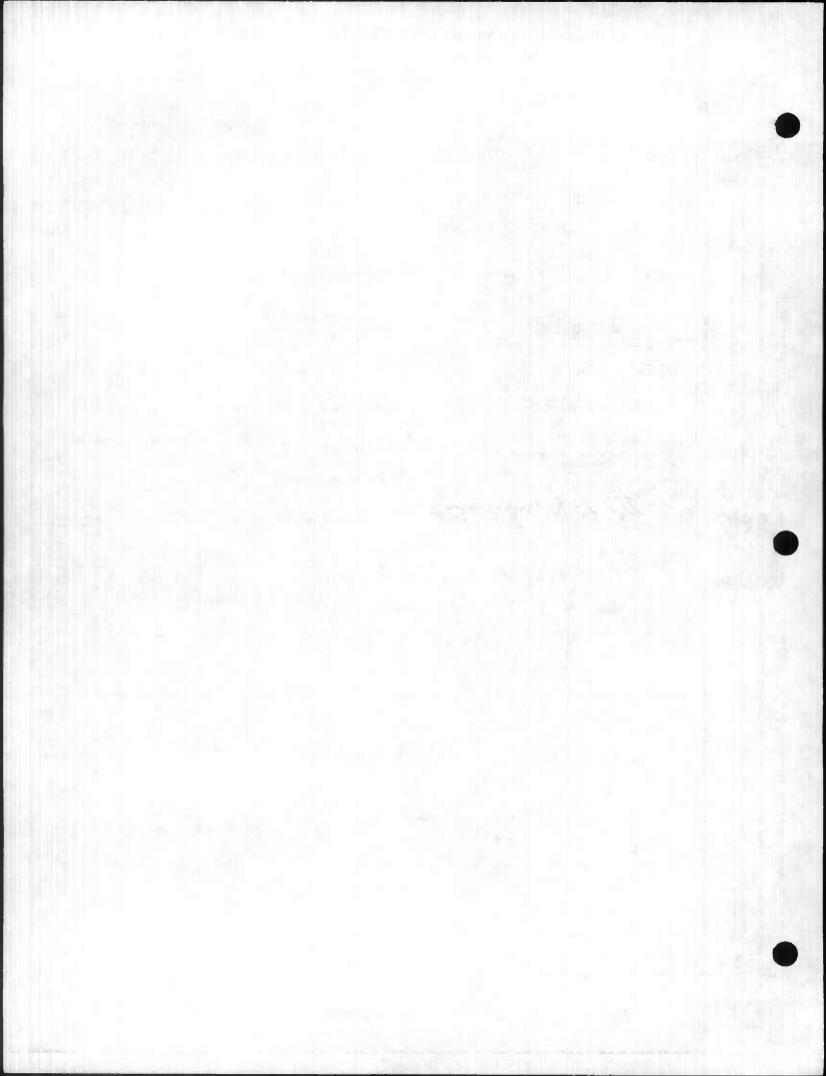
30. Neme and address of person who completed cause of deeth (Itam 23e) (Type, Print)

9101 Cherry Lan. # 205 Laurel, MD 20708

State of Maryland / Department of Health and Mental Hygiene 00 26701

				Cert	ificate	of L	Death		F	Reg. No.			
Ohusisian	1. Decedent's Name (First, Middle	11111							2. Date of Dea		Year	3. Time of Death	
Physician /Medical	Myrtle	Marie		Casey					August		00	4:50 p.m	
Examiner	4a Facility Name (If not institution 4905 Morning (41	Roc	kvi1		Mont	y of Death tgomer	у	
Funeral Director	5. Social Security Number 106–18–4863	6. Sex 1 ☐ M 2XQ F	Age (In yrs. last 76	birthday) Yrs.	If Under 1 Months I	Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day June 4,	7, Year) 1924		ce (State or Fore y) W York	
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Ba-f sho printed a	Maryland Montg	gomery		ville								1 ☐ Yes 2 🕅	
r tems 23s or 28s-ferior man be noursed	10e. Street and Number 4905 Morning (Glory Court			10f. Zip Code 20853					United	What Countr d Stat		
by by	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Wes Deceded Armed Force 1 Yes 2 If Yes, Give Year or Dete	is? Ži No	13. Was Decedent of Hispenic Origin? (Specity Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 1☐ Yes 2☐ No Specify: Specify: White						c.			
2 9 10	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired)					ing	16b. Kind of 8	usiness/Indu	stry	
or the	Elementary/Secondary (0-12)	College (1-4	51 34)	1	Home 1	Make	er			Own	n Hom	e	
Mental Hygiena. arked other than atic event, for Me To Be Compl	17. Father's Name (First, Middle, I								(First, Middle, Nancy				
Tis mer	19a. Informant's Name/Ralationsh William C.	nip (Type, Print) Casey/ Hus							al Route Numbe			20853	
Department of Health and Mental Hygiena. Important: If Item 27 is marked other than any Injury or other treumstic event, the Manages. To Be Compi	William C. Casey/ Husband 4905 Morning Glory Court, Rockville, Md. 208 20a. Method of Disposition 1										n, Stata		
Departre importa any Inju	21. Signature of Juneral Service L 23a. Part1. Enter the disease, or shock, or haart failure. List of	Lollum	un.	22. J	Name and Rapp I	Addres: Tune Lst	ral Ave	and , Si	Cremati lver Sp	ring, M	lary1ar	nd 2091	
ysician Medical taminer	Immediate Cause (Final disease or condition resulting in death)		Me tas	tatio	c (ntarval Between Onset and Death	
physician and stranger the bunel-transit.	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury c.												
S. X	Cause (Diseese or injury that initiated events rasulting in death) Last	c	Due to (or es	a conseque	ance of):								
d by the ettending plateched for use est									23b. Dfd t	23b. Dfd tobacco use contribute to the cause of deat			
signed by the elid be deteched for									10	2 No	3 Probe	ibly 4 🗆 Unki	
0.0 .0				h.					24a. Was perfo	an autopsy med?	com	e eutopsy tindin lable prior to	
s been shou											of de	pletion of ceuse eath?	
s been s shou									101	es 2⊠No		pletion of ceuse eath? Yes 2 No	
s been shou	25. Was casa referred to medical exeminer?	Mosnital:	57			0:50		of Deat	1 Check only o			eath?	
his certificata has been al director, page 2 shour To Be Complete	exeminer? 1 Yes 2 No		atient 2 ERV			Othe	r: 4□ Nu	rsing Ho	n (Check only o	ne)	1 D	Yes 2 No	
his certificata has been al director, page 2 shou To Be Complete	exeminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investig	28a. Data of I	njury Day Year) 281	b. Tima of Injury	M 280	. Injury Work 1 Y	r: 4□ Nu	rsing Ho	me 5 KD Residence 128d. Describe h	ne) ence 6 Oti ow injury occu	1 □ her (Specify) rred	eath? Yes 2ŽNo	
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within 24 hours effer death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should make the formula of the following the formula of the following th	exeminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n 4 Homicide detarmi 29a. Certifier (Check only one)	28a. Data of lation of be ned 28e. Place of building.	njury 281 Day Year) Injury - At home, etc. (Specify) st of my knowleds of examination	b. Tima of Injury , farm, stree	M 28c	Injury Work 1 Y office the time i my op	at ? es 2 =	No d place, th occurr	me 5 N Residence only of the second of the s	ne) ence 6 Ottow injury occu street and Num m, State) eausa(s) and m date and place,	her (Specify) rred ber or Rural eannar as ste	Poute Number, ted tha cause(s)	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** August 7, Yong Hwan 2000 5:06 AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Sep. 7, 1924 5. Social Security Number 6 Sev Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1⊠M 2□ F 75 Yrs. 161-50-9470 Director Korea Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or itema 23a or 28a-f shoury or other traumatic event, the Medical Exertion must be nother 1 ☐ Yes 2 No Directo Maryland Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14644 Almanac Drive Funeral Korea 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify Specify: þ Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cottege (1-4or 5+) Mechanic Automobile Repair 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Unobtainable K. N. Ko To 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Kenny Cho / Son 1563 Onyx Drive, #B30, McLean, Virginia 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Department of Important: If any injury or Gate of Heaven Cemetery 08/09/00 Silver Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue Silver Spring, Maryland 23a Part. Enter the dises plicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Obstructive Jaundice 5 weeks diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Tumor of Portal Hepatis The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest and the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? á 1 Yes 2X No 3 Probably 4 Unknown Gall stones, common bile duct stone, signed t Division of Vital Records, Completed by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Right pleural effusion, completion of cause of death? 2 X No 1 ☐ Yes 2 ☐ No Anemia thrombocytopenia 1 Yes Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☒ No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturat 5 Pending death. 1 Yes 2 No To the Hospital or Attendition 24 hours after death.

To the Funeral Director: A investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Medical 29e. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as stated. completaly (Check only one) 2 Madical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2090

DHMH 16 Ray 6/95

State

Registrar

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31. Date filed (Month, Dey, Year)

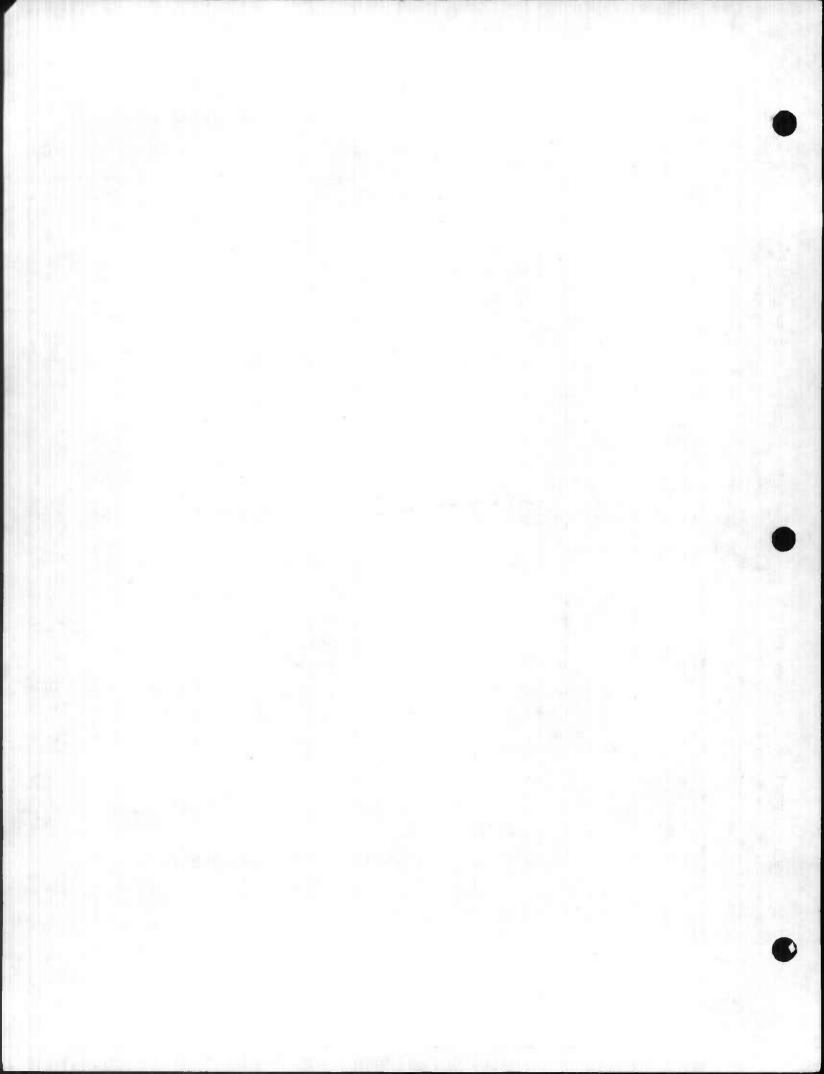
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32. Registrar's Signature

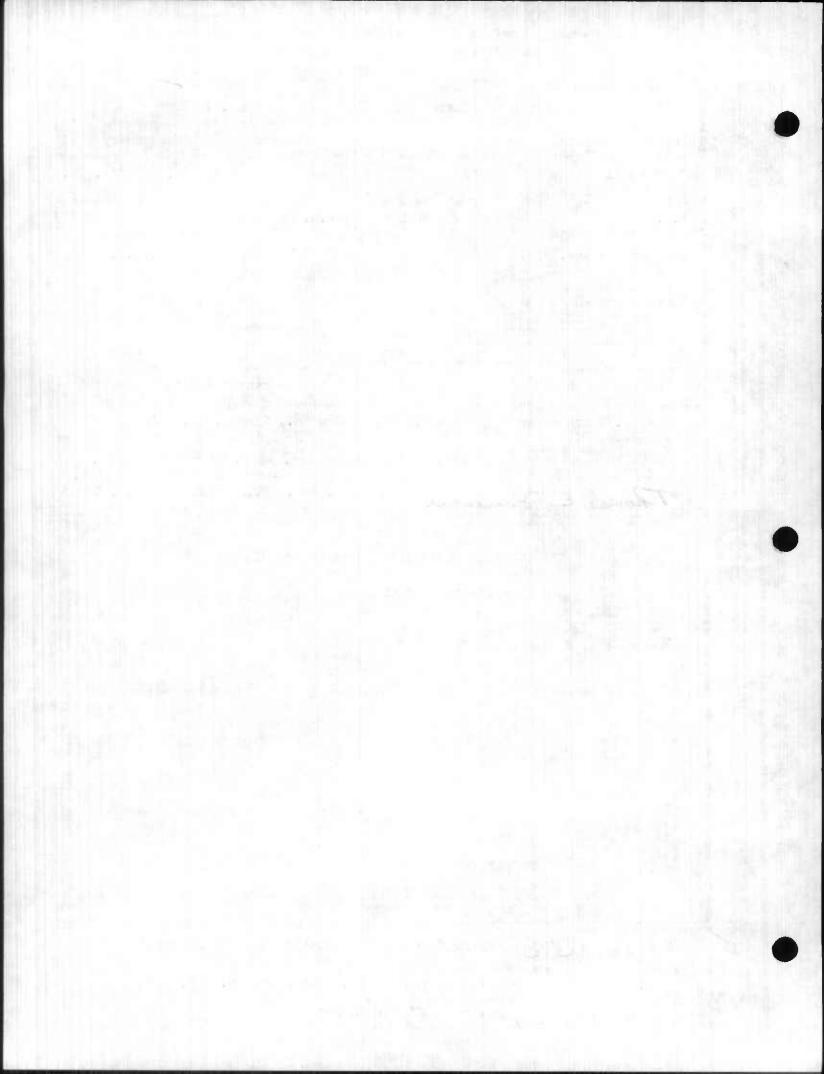


State of Maryland / Department of Health and Mental Hygiene

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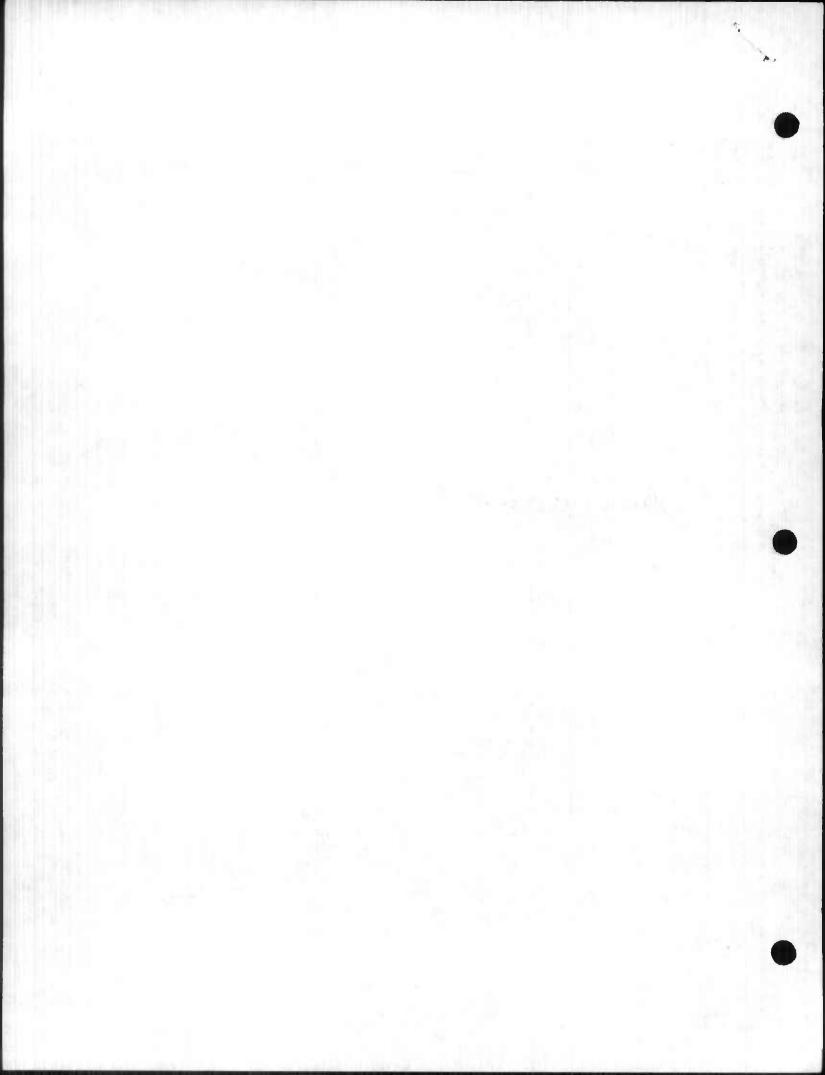
					Cel	titicate c	T Death		Reg. No.				
	ysician	Decedent's Nama (First, Middla Eleanor	(Last) Albaugh	C1a	rk			2. Data of Month Aug.	Death Day 7, 2000	Year 3. Time of Death 7:55 P.M.			
	Medical caminer	4a Facility Neme (If not institution		um <i>ber)</i>			4b. City, Tov	vn, or Location of De		y of Death			
		Suburban Hospit	a1				Bet	hesda	Montg	gomery			
	neral ector	5. Sociel Security Number 578–52–0081	6. Sex 1 □ M 2 🖾 F	7. Age (fn yrs. 8.5	last birthday) Yrs.	If Under 1 Ye Months Da		Min. (Month,	Birth Day, Year) 6, 1915	9. Birthplaca (Stata or Foreign Country) Phila. Pa.			
71	Ctor	Usuel Residence of Decedent		0.5				I Lary 2	0, 1713	Initia ia.			
yland Now	14	10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation	3 17			10d. Inside City Limits			
3 7	the stor	D.C.			Wash:	ington,	D.C.			1 Yas 2 □ No			
6 %	Director	10e. Street and Number				10f. Zip Cod			10g. Citizen of	What Country?			
4 G	1 10	6200 Oregon Ave	#257				20015	5	U.	.S.A.			
20 a sher des	Daminer must be notified at by Furneral Director	11. Marital Status 1 Never Marriad 2 Marria 3 Widowed 4 Divorced	Armed F ed 1 Tas If Yas, G	2 X No		Was Decedant of Yas, specify C		in? (Specify Yas or , Puarto Rican, etc.)	Bta	ca - Amarican Indian, nck, Whita, atc. Ny: White			
8 2 1			Yaar or I	Datas:	16e Decer	lant's Usuel Oc	cupation		16b Kind of B	Business/Industry			
15 m	c. the Medical	15. Decedent (Specify only highes	t grade completad)	(Giva	kind of work do	na during most	of working	TOU. KING OF E	oanies a noustry			
vitte Pen	Mad dimo	Elemantary/Secondary (0-12)	Collega	(1-4or 5+)		omemake			House	ewife			
D DE		17. Fethar's Name (First, Middla, I	.ast)					r's Nama (First, Mide					
and the second	o Be	Harry Albaugh						Margaret	rgaret Strider				
Maryland 21215-0020 of 2 should be fluid within 72 hours at ith and Mental Hygens. 77 is marked other than "natural", or	D C	19a. Informant's Name/Ratationsh			19b Mailtir	ng Addrass (Str		r or Rural Routa Nut		s. State. Zip Code)			
Ma md 2 s sith ar 27 ts		Robert B. Clark						, Vienna,					
	the	20a. Mathod of Disposition		20b. I	Place of Dispo	sition (Nama of natory or other		Deta	_	- City or Town, Stata			
no n	8	1 X Burial 2 ☐ Cramation		0/2//00	8/24/00 Arlington, Va.								
Baltimore, semit. Pages 1 a Appartment of Hear	Critical Cri	4 Donation 5 Other (Sp 21. Signeture of Funeral Service L			seph Gawler's Sons, Inc.								
Ba made	any	21. Signeture of Purlarar Service D	icensee	. 0						D.C. 20016			
		-homas	= · do	nulak	er								
	- 53	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only ona causa on	caused the daal aach lina.	th. Do not ent	ar tha moda of	dying, such as o	cardiac or raspirator	/ arrest,	Approximate Intervel Batween Onsat and Death			
Physic /Med	_	Immediate Court (Since)								Onsat and Doute			
Exam		Immedieta Causa (Final diseasa or condition rasulting in death)	a. Chr	onic Ob	struct	ive Res	pirator	y Disease					
	7			Dua to (or as a consec	juance of):							
2	isi i		b. Res	pirator	-								
and	ial-transit Examiner	Sequantially list conditions, if eny, laading to immediate cause. Enter Undarlying Cause (Disease or injury		Dua to (or as a conseq	uance of):							
60 bee	bunia Bal	cause. Enter Undarlying Cause (Disease or injury	C										
ox 68760, certificate be executed	isa as the burial-fransit	thet initiated avents resulting in daath) Last		Dua to (c	or as a conseq	uanca of):							
OX (VM.		d										
death	foru												
. 0 0	hed ys!	Part II. Other significant condition	significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco uss contribute to the cause of deat				
P.O. that the	deta								☐ Yss 2☐ No	3 ☐ Probably 4 ₺ Unknown			
S & C	2 2							242 W	as an autopsy	24b. Wara autopsy tindings			
nber /	page 2 should							pe	orformad?	available prior to completion of cause			
Rec e law	mpl								**	of death?			
= - 4	. page							1	□ Yas 2 No	1 ☐ Yes 2 ☐ No			
Of Vital IP Physician: The	director.	25. Was casa rafarred to medical axaminar?	Manital					of Death (Chack on	ly ona)				
Of Physic	To	1 ☐ Yes 2 ☒ No		Inpatient 2		-		rsing Home 5□R					
E & \$	noi	27. Manner of Death 1 ⊠Natural 5 □ Panding		of Injury nth, Day Year)	28b. Tima o Injury		njuryat Work? I□Yas 2□N		be how injury occu	med			
ISIO thendi death ctor: A	by the	2 Accident Investigation 3 Suicide 6 Could not be							n (Street and Num	ber or Rural Routa Number,			
Division Attendated after deat	erti	4 Homicida detarmi	build	 Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 					Town, Stata)				
pitel	E	29a. Certifier 1 Certifying	Physician: To th	a hest of my kno	teeb enhelwe	occurred at the	e time date and	d place, and dua to t	ha causa(s) and m	nannar as stated			
To the Hospital within 24 hours a To the Funeral I	completely filled in	29a. Certifier (Check only one) 29a. Certifier 4 the time, date and place, and due to the causa(s) and mennar as stated. 29a. Certifier 4 the time, date and place, and due to the cause(s) and mennar as the cause(s) and mennar stated.											
o vithir	Me	29b. Signetura and title of certifiar		1		29c. Lic	ense number	W. Land	29d. Data sign.	ad (Month, Day, Year)			
- 3 -	15	1 /21	5	Loon	6		D56065		August	9, 2000			
		30. Nama and addrass of person v		,		Print)							
		C. Picone, MD. 8600 Old Georgetown Rd., Bethesda, Md. 20814											
	State	31. Data filed (Month, Day, Year) 32. Pegistrar's Signatura											
Re	gistrar	AUG 11	2000	freve	p.	pour	N						



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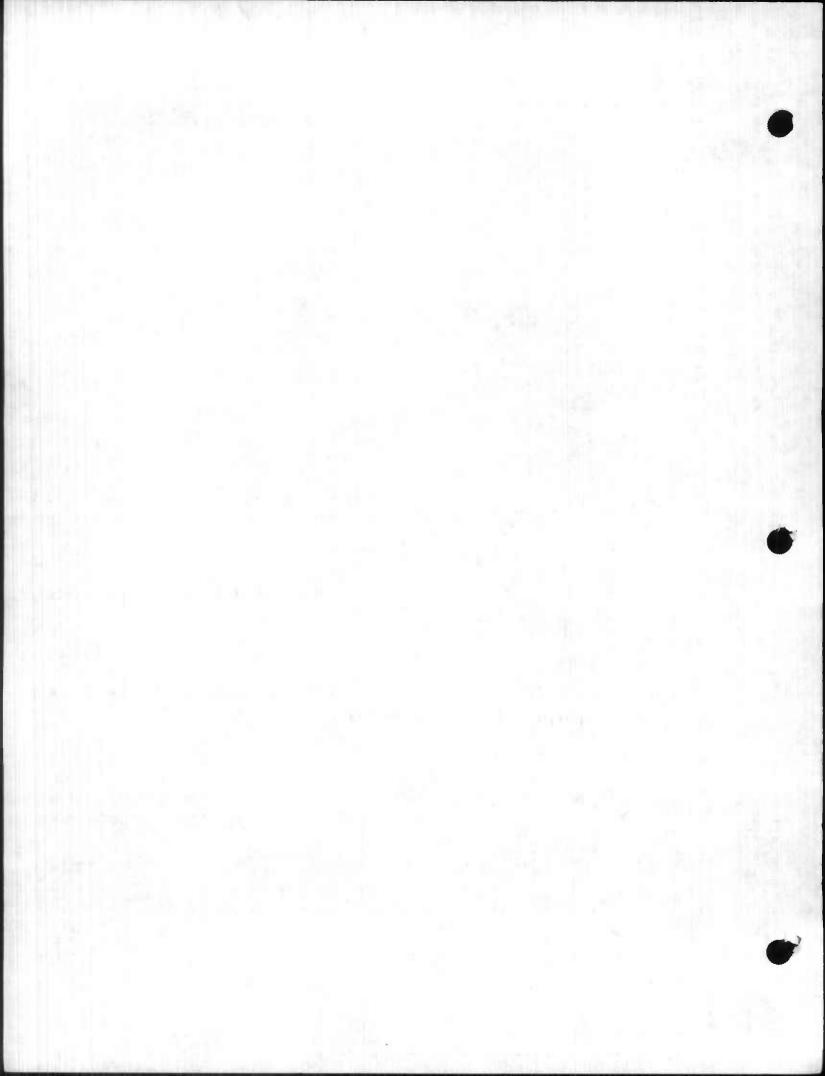
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7 /20								Death			ng. No.		
	00 BW Montg 1. Decedent's Name (nst)						2. Date Mor	of Deat		Year	3. Time of D
an al	Peggy R.	. Coat	es							LY	29	2000	9:39
	4a Facility Name (If no	ot institution, giv	e street end nun	n <i>ber)</i>			4	4b. City, Town, or	Location o	Death	4c. County		
	DOCTORS CO	MMUNITY	HOSPIT	'AL				LANHA			PRIN	ICE GEX	ORGE'S
	5. Social Security Num 578-50-63	64	Sex 1□M 2Å F	7. Age (In yrs	last birthdey) 65 Yrs.	Months	1 Year Days	If Under 24 Hr Hours Mir	n. (Mor	of Birth hth, Day, g . 1	Year) 193	9. Birthple Countr VII	ce (Stete or y) ginia
-	Usual Residence of De 10a. State	Ob. County		10c. C	ity, Town or Lo	ocation						10	d. Inalde City
	MD	Prince	George	Lar	nham								1 ☐ Yes
-	10e. Street and Number 6927 Stor		le			10f. Zip	Code 207	706		16	10g. Citizen of What Country? USA		
	11, Marital Status 1 Never Merried 3 Widowed 4		Armed For	2X No	If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) BI							ce - America ck, White, et	tc.
		5. Decedent's E	Year or Do	ates:	16a Dece	dent's Usue	's Usuel Occupation 16b. Kind of Business/Industry						
	(Specify Etementary/Second	only highest gri	ade completed) College (1	-4or 5+)	(Give	kind of work DO NOT use Lerk	rk done	during most of wi	orking		Sto		
Ī	17. Father's Neme (Fin	irst, Middle, Last	1)					18. Mother's Na	ame (First, i	Middle, A	Aeiden Sumen	ne)	
	William F	. Murra	у					Edmon	Edmonia Harris				
19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 1172 / May 128 / Print)									Code)				
Timothy Coates (Son) 11734 Tuscany Drive Laurel, MD 20708													
20e. Method of Disposition 20b. Plece of Disposition (Neme of carriery, cremetory or other place) 20c. Location - City or Tow carriery, cremetory or other place)													
any one	4 Donation 5 Other (Specify) Fairview Cemetery 8/4/00 Waynesboro, V									, VA			
	21. Signature of Fune	oral Service Lice	nsee	100	0 2	2. Neme and McCu	d Addre	ess of Fecility	neral	Hom	.e		
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ner	23 Fart / Enter the hook, or heart f Immediate Ceuse (Fir disease or condition resulting in death)		. R	VPTVA	CED A	HBDEN inquence of):	e of dyin	n Aor	ac or respire	ANE	urysm		22980 Approximate Interval Betw Onset and Do
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State of Maryland / Department of Health and Mental Hygiene 00 26705

			Certificate of Death				Reg. No.			-0100		
Physician	1. Decedent's Nama (First, Middle, I		The same					2. Data of Dea Month	Day	Year	3. Time of Death	
/Medica		onnell				15.05		August	3, 20	00	8:52P.	
Examiner	4a Facility Name (If not institution, g Washington Adv					Takor	na Pa			of Death	ery	
Funeral Director	222-01-6393	Sex 7. A 1 ☐ M 2 ▼ F	ge (In yrs. last birth 88 Y	Adamsh a	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day August 24	1,1911	9. Birthpi Coun De I a	laca (State or Foreign lry) IWare	
the Maryland 28a-f show notified at	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City, Town						10d. Inside City 1 ☐ Yes 3			
1 08 2				10f. Zip Code 20783				1	10g. Citizen of What Country? United States			
020 ors after death v all, or heres 23 Exeminer must	3 X Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 12 Yes 2 If Yes, Give Year or Dates:	If Yas, specify Cuban, Mexican,			gin? (Spe , Puerto	n? (Specify Yes or No- Puerto Rican, atc.) 14. Ra Bla Speci			an Indian, etc. te		
Maryland 21215-0020 and 2 should be filed within 72 hours at sith and Mental Hygiens. 27 is marked other than "natural", or or traumatic event, the Medical Exam.	15. Decedent's (Specify only highest (Specif	5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Special Education Teacher				ng	Anne A School	runde	e1 Co.		
Viand be file Mental Hy mand other mic event,	17. Father's Nama (First, Middle, La	Thomas Di						Dwyer Nora Dineer				
e, Mary	19a. Informant's Name/Reletionship	(Type, Print) (daughter)							reeland	, Mar	yland 21053	
altimore mit. Pages 1: partment of Hs portent: if her r injury or oth	20a. Method of Disposition 1 XBurial 2 Cramation 3 4 Donation 5 Other (Special Control of Control		20b. Place of I cemetery.	crematory or	other plac	ce) Cemet	tery		20c. Location - 00 Ade1		wn, State Maryland	
Balt Permit. Pepart Importu	21. Signature of Funeral Service Lic	Boranka	alt	Dona I 4400 P	nd Addra d V. owde	ss of Facility Borgv r Mill	ward	t Funera	al Home	, P.A Maryl	and 20705	
bhysician and lifete be executed the punishinant as the bunishinant and bunishinant and as the bunishinant and bunishinant and as the bun		a. Atr	Due to (or as a co	ensequence of	elle	atic				Sponse	20 mins 8 months	
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death c	Part II. Other eignificent conditions	contributing to deeth l	out not resulting in	the underlying	cause div	en in Pert I.		23b. Did to	obacco uee co	ntribute to	the cause of death?	
IS, P.O. BOX es that the death cer igned by the attendir be detached for use hy PhysicianA	Polymyala	ia Rh	ieuma	tico	h			1 U Y	23b. Did tobacco use contribute to the c		bebly 4 Unknown	
COrd requir	Pancytop	penia	1 /		y B			24a. Was a perfor		av	ere autopsy findings ailable prior to mpletion of causa death?	
Vital Receiption: The law certificate has lirector, page 2	25. Was case referred to medical	Myoz	pathi	1		26. Place	of Death	1 🗆 Y		10	Yes 2/(No	
- 5 in		Hospital: 1 ☐ Inpat	ent 2 ER/Out	patient 300	OA Oth	ier: 4 Nu	rsing Ho	me 5 Resid	ence 6 Oth	ner (Specif	(y)	
After fune			ay Year) 28b. Tii	me of `ury M	28c. Injur Wor 1 🗌	yet k? Yes 2 □ I		28d. Describe h	ow injury occur	rred		
Division of the or Attending P as after death. al Director: After the funer led in by the funer Certification:	3 Suicide 6 Could not 4 Homicide determine	d 200. Piece of it	jury - At home, ferr tc. (Specify)	n, street, facto	ry, office			28f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	I Route Number,	
he Hospi in 24 hou he Funer pletely fill	29a. Certifier critifying (Check only and the control one)	Phyeician: To the best aminer: On the basis of end manner s	of examinetion and									
To the Troth Troth	Momas	W-Clas	culis, u	1.D.	D 52	e number 2401			egd. Date signe Aug		Day, Year)	
	Thomas Annulis, 1	1.D. 11120	New Hamp	shire	Avenu	ie, #3	305 \$	Silver S	Spring,	Mary	land 20904	
State Registrar	31. Date filed (Month, Day, Year) AUG 08		rar's Signature	9. 4	ack.	2						

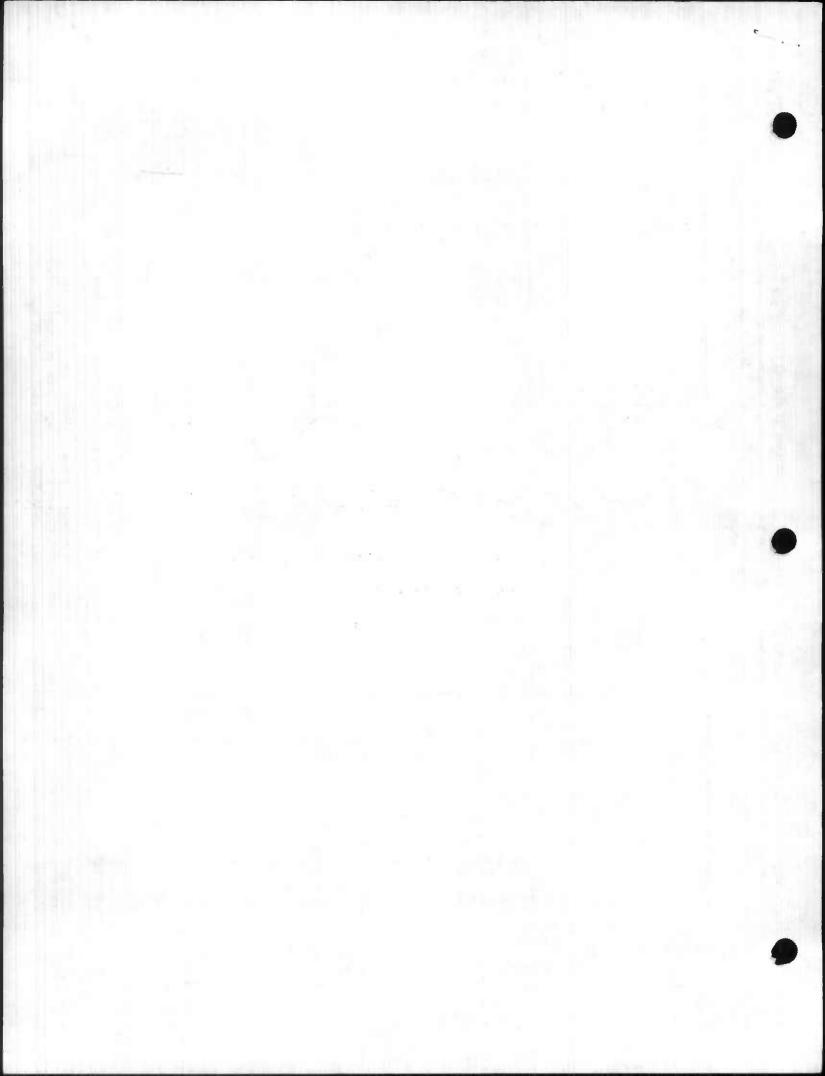


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #8,8/9/2000, BMW, Montq.Co. Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** James Robert Coyner August 6, 2000 6:10 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laure1 Prince George If Under 24 Hrs. 8. Data of Birth 1934 9. Birthplace (Stata or Foreign (Month, Day, Year)
March 8, 2000 Virginia 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year **Funeral** Days 1EYM 2□ F Hours Months 224-40-1704 66 Yrs Director Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo 288-1 Maryland Prince George **Beltsville** must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Harma 23a or 11709 Pine Street 20705 Funeral United States 14. Raca - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status the Medical Examiner 72 hours after 1 XYas 2 No 1 ☐ Nevar Married 2 Married 21215-0020 8 1 Yas 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. filed within Elamentary/Secondary (0-12) College (1-4or 5+) Telephone Technician 12 Bell Atlantic or traumatic event, Baltimore, Maryland 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Pages 1 and 2 should be to ment of Health and Mental H ant; if them 27 is marked off Be Garland M. Priddy Beulah Helen Massie 10 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Sharon Morrill/daughter 12540 Summerwood Drive Silver Spring, Maryland 20904 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 'n George Washington Cemetery 8/9/2000 Adelphi, Maryland 21. Signatura of Funaral Sarvice Licania 22. Nama and Address of Facility à Donald V. Borgwardt Funeral Home, P.A. 23a. Part1. Entar tha disaase, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate

Approximate Approximete Interval Between Onset and Death Physician /Medical Immedieta Causa (Final disaasa or condition rasulting In daath) Small Cell Lung Cancer 1 month Examiner Due to (or as a consequence of) Examiner Metastasis To Liver burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): pue The law requires that the death certificate be execu physician a the burial Cardiorespiratory Arrest Box 68760 Physician/Medicai Dua to (or as a consequence of): 88 980 signed by the a Part II. Other eignificent conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Yee 2 No 3 Probably 4 Unknown à 24b. Ware autopsy tindings evailable prior to Completed 24a. Was an autopsy performed? peen : complation of cause of death? has page 2 this certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: funeral director, Be 25. Was case raferred to medical axaminar? 28. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 2 No Certification: To 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending invastigation 1X Natural To the Hospitan or within 24 hours after death.
To the Funeral Director: A 1 Yes 2 No 2 Accidant 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiai edical (Check only one) 29b. Signeture and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) Ischelle D45014 August 7, 2000 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Isabella Martire, M.D. 8379 Cherry Lane, Laurel, Maryland 20707 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State AUG 09 Sepera Registrar 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death reamer fizabeth JANE 2000 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) CIT +ODICINS Has he Johns If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrd. last birthday) 5. Social Security Number 1□M 20 F Months Days 9, 68 DC 220-28-6953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15105 Emory Lane 20853 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Never Married 2 Merried 1 ☐ Yes 2 DNO Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Nursery School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) William Golden Ethel Mullikin 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Creamer/ Husband 15105 Emory Lane, Rockville, MD 20853 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetlon 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/10/00 Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Fecilit Francis J. Collins Funeral Home, Inc. milk 500 University Blvd., W. Silver Spring, MD 20901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final 2 Hours disease or condition resulting in death) 6 Hours NEUMONIA

Physician /Medical Examiner

the

page 2 should be

al or Attending Physician: The setter death.

I Director: After this certificate the funeral director.

To the Hospital within 24 hours e To the Funerel D

Physician

/Medical

Examiner

10a. State

Funeral

Director

or items 23s or 28s-f show

"neturel".

Hygiene.

Department of Health and Mental Important: If Item 27 is marked or Peges 1 and 2 should be

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other

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

of Vital Records.

Division

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be Completed by Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

29b. Signature end IIII

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 TY Yes 2 No 25. Wes case referred to medicat axaminer? 26. Place of Deeth (Check only one) Hospitat: 1 PInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes/ 2 No 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier

29c. License number

20190

20

completely filled in by

MU JOITHS MAETOLA 19ASSIM

- 2000

HOSPITAL BALTIMORE

29d. Date signed (Month, Day, Year)

MA 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

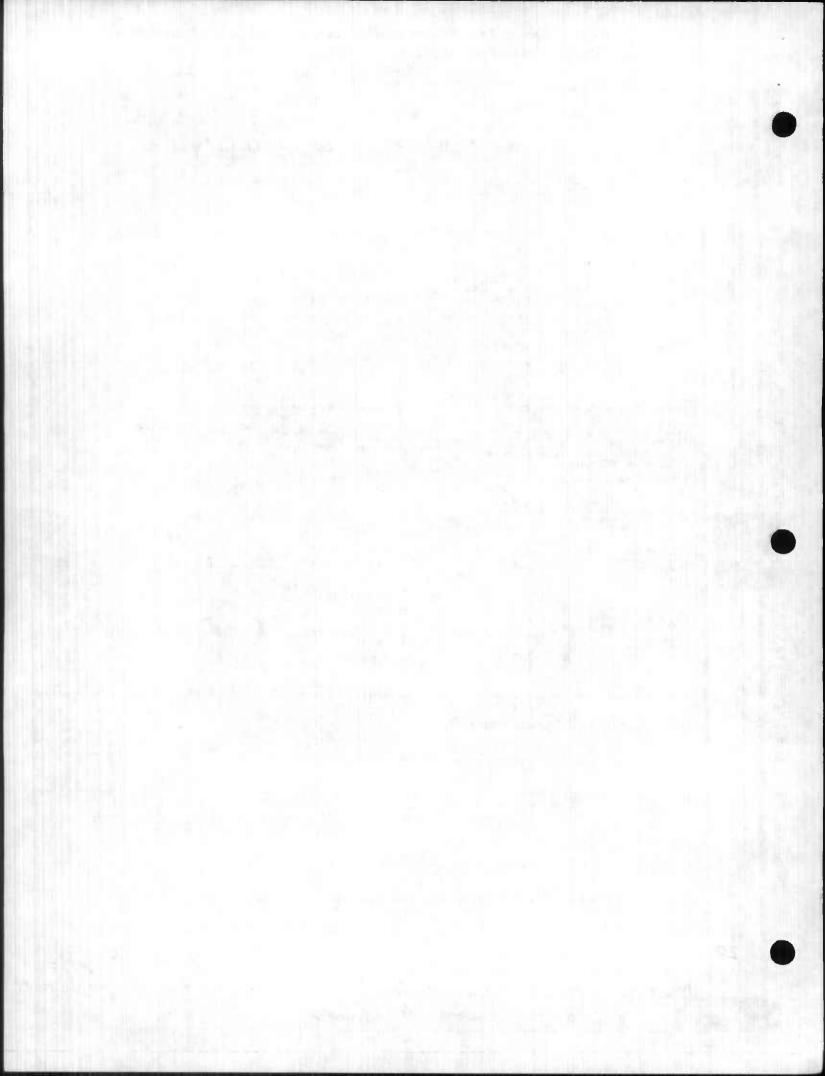
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State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year) AUG 09 2000

MOPKINS 32. Registrar's Signeture reperson

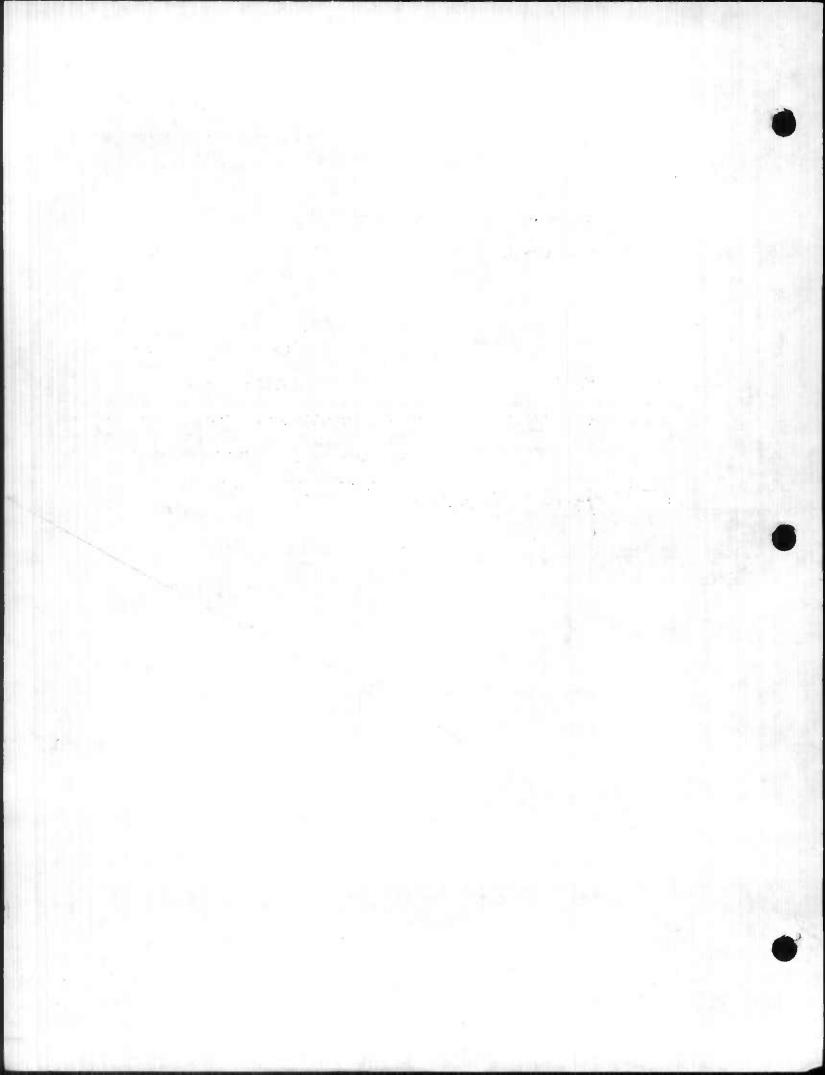


State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificat		Death			ı. No.	UU	20100
		1. Decedent's Name (First, Middle,	Last)							Pata of Death Month	Day	Year	3. Time of Death
N.	Physician /Medical	RUTH E.	CROSS							UGUST	6, 2	000	8:30 PM
	Examiner	4a Facility Nama (If not institution,	giva street and nun	nber)				b. City, Town,	or Locatio	n of Death	4c. County	of Death	
		Montgomery V	illage	Care &	Reha	ab		Gaith			MONT		ERY
	Funeral Director	215-38-5885	5. Sex 1 □ M 2√2 F	7. Age (In yrs. las 63	t birthday; Yrs.	If Under Months		Hours N	Hrs. 8. D	Date of Birth Worth, Day, 1 ulv10	(ear) ,1937	9. Birthp Cour Ma	lace (State or Foreign try) ryland
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	or 28a-1 s be notified Director	MD Montg	Ollery		ROCI	(Vill				100	. Citizen of V	What Cour	trv?
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	her desth here 23 iber must Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Dece	dent of H	lispanic Origin' an, Mexican, P	? (Specify	Yes or No-			an Indian,
Maryland 21215-0020	by by	1 ☐ Nevar Married 2 ☐ Marrie 302 Widowed 4 ☐ Divorced	Armed For d 1 Tas If Yas, Give Year or Da	2 (X)No		If Yes, spec			uerto Ricar	n, etc.)		k, White,	
50	ed within 72 ho rglene er then 'naturn i, the Medical. Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua	al Occup	ation during most of	working	16	6b. Kind of Bu	usiness/Inc	dustry
121	mpie	Elementary/Secondary (0-12)	College (1	-4or 5+)				during most of			Montg).
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Baltimore	t. Pages trant of tart or o	1 ☑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	tata .	col	n Par	ck C	lem.	8/1	4/00			
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	erificate be executing physician and e as the bunal-trer	resulting in death) Last	d	Due to (or a	s a consec	luence or):							
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P.0.	y the checked	Part II. Other significant condition	s contributing to de	ath but not resulti	ng in the u	inderlying c	ause giv	en in Part I.					the cause of death?
0	that ned b dete									1 L Yes	2 □ No	3 Pro	bably *KUnknown
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o	Physic or this co erel dire	27. Manpar of Death	28a. Date o	f Injury 21	8b. Time o		Bc. Injur		-	Describe how			y)
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N N	Attendes by the	3 Suicide 6 Could no detarmin	ad 250. Place	of Injury - At home	e, larm, st	reet, lactory	, office			ocation (Stre		er or Run	al Route Number,
	and in Cert	4 🗆 Homicide	Dulldin	g, etc. (Specify)						Aty or Town,	Siere)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2: Medical Certification: To Be Comp	29a. Cartifiar (Check only one) 1 Certifying 2 Medical Ex	Physician: To the taminer: On the ba	sis of axamination	edge, deat n and/or in	h occurred vestigation	at the tir , in my o	ne, data and pi pinion, death o	lace, and d	ue to the cau the time, dat	se(s) and ma a and place,	nner as s and due to	tated. o the cause(s)
	within To the comp	29b. Signatura and titla ol certifier				290	. Licens	e number		290	d. Date signe	d (Month,	Day, Year)
	4	AHank	asid.	M.D.,	Ph	D.	1	55	05	4 A	UGU	ST	08 200
		30. Name and address of person w	no completed cause	of death (Item 2	3a) (Type,	Print)	P	FDIA	MD	80	A-D	ROC	08 200 0855 KVILLEM
	Control	31. Data filed (Month, Day, Year)	N 1 30 Pm	gistrar's Signatur	115	717	7		· · ·	1	,		140
	State Registrar	AUG 09	2000	person	19.	do	uks	,					

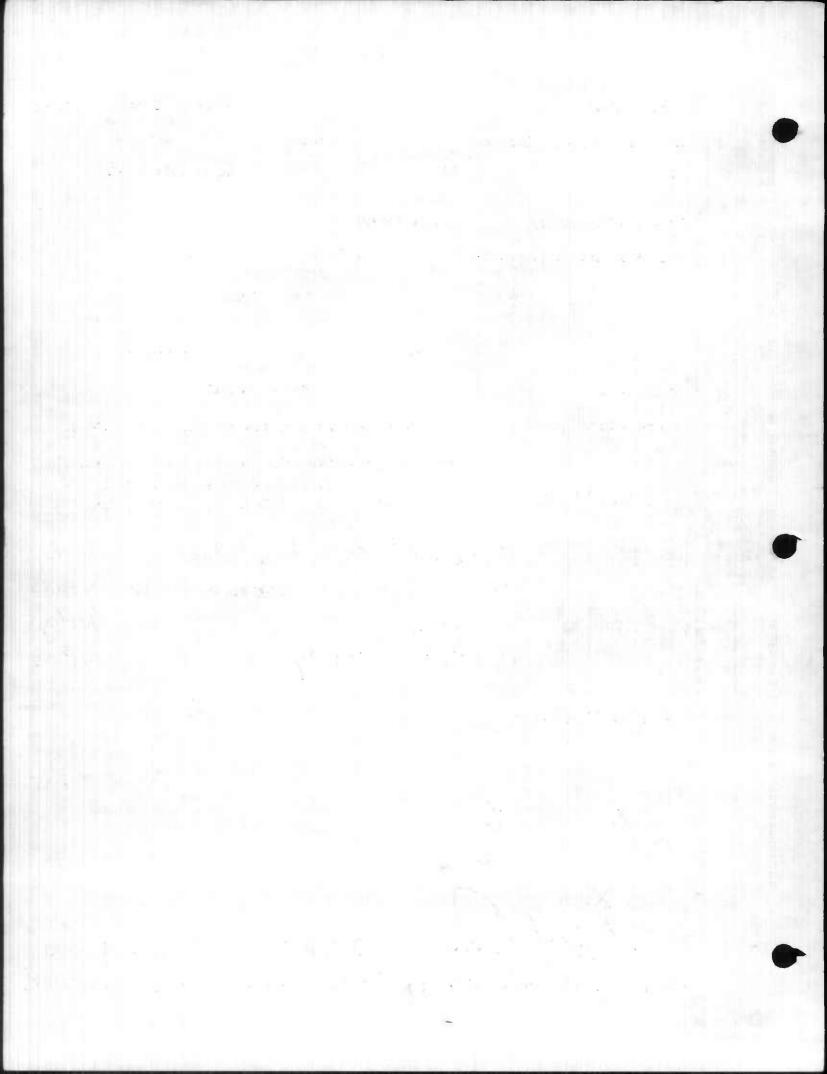
DHMH 16 Rev 6/95



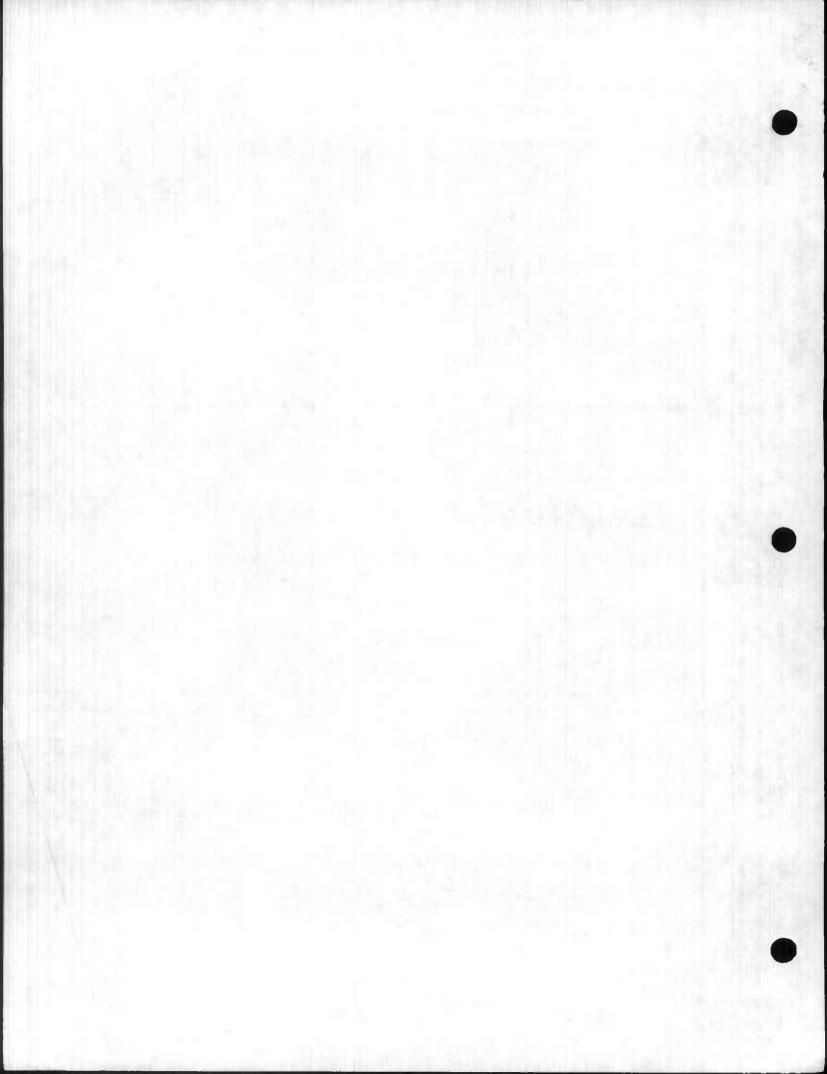
State of Maryland / Department of Health and Mental Hygiene 00 26709

	Certificate of Death	Re	g. No.	20102	
	1. Decedant's Name (First, Middle, Last)	2. Data of Death Month		3. Tima of Death	
Physiciai /Medica		August	4, 2000 Year	2:06 pm	
Examine	45 English Name (Mast institution give street and number)	ocation of Death	4c. County of Dea	th	
	Montgomery General Hospital Olney		Montgomer	У	
Funeral Director	5. Social Security Number 264-95-1606 6. Sex 1 M 2 F 7. Aga (In yrs. last birthday) 48 Yrs. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Aug 6,	9. Bir 1951 Cul	thplaca (State or Foraign buntry) 3 a	
and *	Usual Rasidenca of Dacadent 10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits	
he Mary 28s-f aho cut ed	Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code	10	og. Citizan of What Co	1 Yas 2 XNo	
effer death with the Marylar or items 23s or 28s-f show		U	SA		
S & 4	2 3 Widowed 4 Divorced Year or Dates:	Rican, atc.)	14. Race - Ame Bleck, White Specify: W]		
5-00 72 hours netural;	15. Decedant's Education 16e. Decedant's Usual Occupation (Spacify only highast grade complated) (Giva kind of work done during most of work	dna 1	6b. Kind of Business	Industry	
T C 1 4 4	Elamentary/Secondary (0-12) Collega (1-4or 5+) lifa. DO NOT use retired)				
d 2121 filed within Hygiene. ther then ent, the Ve	Chef		Restaurant		
faryland 212 2 should be filed within and Mental Hygiene. Is marked other than sumatic event, to M	m	a (First, Middla, M	aldan Sumame)		
2 should be and Mental is merked o	Pedro Cubas Carmen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rur		City or Town State	Zin Codo)	
or Haalth of Haalth Fittem 27	Ramon Cubas/ Brother 1928 Santa Monica, San 20a. Method of Disposition 1 Mana of Camatary, cramatory or other place)	n Antonio	O. Texas	78201 Town, Stata	
tim then tant: stury		8/7/00 3	Silver Spr	ing, MD	
Baltimo permit. Pag Department Important: It any Injury o	21. Signeture of Funaral Sarvica Licensee 22. Nama and Addrass of Facility Francis J. Collins	Funeral	Home, Inc		
Physician	23a. Phot. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	d., W, S: or raspiratory erra	ilver Spri	ng, MD2090 Approximata Intarval Batween Onset end Death	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hercarbic Respiratory Due to (or as a consequence of): The second of the second or sec	Failur-	9	10 days	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents Due to (or as a consequence of): PRUMONIA Due to (or es e consequence of):	orareg r	-17002	10 days	
S S S S S S S S S S S S S S S S S S S	MORRTD OBESITY			years	
na deat the ett	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tol	bacco usa contribut	to the cause of death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension	1 V	8 2 No 3 F	Probably 4 Unknow	
of Vital Records, Physician: The law requires this certificate has been signs ral director, page 2 should be	Completed	24a. Was ar perform		Were autopsy findings available prior to complation of cause of death?	
The law ate has pege 2	E CONTRACTOR CONTRACTO	1□ Ye	s 2 No	1 Yas 2 No	
VITAL The victan: The certificate rector, per	25. Was casa rafarrad to medical 26. Placa of Deal	th (Check only one	9)		
Of VITA Physician: this certific ral director,	axaminar? 1 Yas 20 No Hospital: 1 Inpatient 2 ER/Outpafient 3 DOA Other: 4 Nursing Ho	oma 5 🗆 Rasida	nce 6 Other (Spe	ecify)	
To the Hospital or Attending Physwithin 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral director.		28d. Dascribe ho	w injury occurred		
Division To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral Director.	27. Manper of Baath 1 Natural 2 Accidant 3 Suicide 4 Homicida 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury M 28b. Tima of Injury M 1 Yes 2 No 28a. Placa of Injury M 28b. Tima of Injury M 1 Yes 2 No 28a. Placa of Injury M 28b. Tima of Injury M 1 Yes 2 No 28a. Placa of Injury M 1 Yes 2 No	28f. Location (Str City or Town	reet and Number or F , Stata)	ural Routa Number,	
To the Hospital within 24 hours To the Funeral completaly filled	29a. Cartifiar (Check only one) 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction on the best of my knowledge, death occurred at the time, date and place, construction of the best of my knowledge, death occurred at the best of my knowledge, death occ	, and dua to the ca red at the time, da	usa(s) and mannar a ata and place, and du	s stated. a fo the cause(s)	
o the	29b. Signature and the of chilifier,	29d. Data signed (Month, Day, Year)			
3	18/14 Colin D5/908	1	August 4	12000	
	30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)	, 0/	100 111	ryland	
State	MILLED TO DODD AND AND MARKET MARKET	ive or	vier vila	Rylance	
Registra	HOU (ZUUU) A TOO D. POPOLICE				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** August 3, 2000 2:30 am Leo Michael Curtis /Medical 4b. City, Town, or Location of Death 4a Facility Nama (Il not institution, giva street and number) 4c. County of Death Examiner Gilchrist Hospice Towson If Under 1 Yeer | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F Yrs. 89 Director 220-44-3320 April 7, 1911 Maryland Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Directo Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? United States 20815 8507 Lynwood Place Funeral 14. Race - Amaricen Indien, Black, Whita, atc. 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Meritel Stetus 1 ♥ Yas 2 No 1 Nevar Merried 2 Married 1 ☐ Yas 2 ☒ No Specify. 3 X Widowed 4 □ Divorced White Year or Dates: WW II 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Private Practice 5+ Physician 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Jan Czekaj Marjanna Chronowska 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 12302 Cliveden Street Herndon, Virginia 20170 Daniel M. Curtis/ Son 20b. Placa of Disposition (Nama of cemetery, crematory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata August 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 7, 2000 Silver Spring, Maryland 21. Signature of Furieval Service Licenses Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 carons that cardsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final month diseasa or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disease or Injury that initiated events rasulting in death) Last Dua to (or es a consequance of): Physician/Medical Due to (or es a consequance of): Box (P.O. Part II. Other significant conditions contributing to death but not rasulting in tha undarlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by of Vital Records, 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was en autopsy 2 No 1 Yas 1 Yas 2 No or Attending Physician: 25. Was cesa refarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Medical Certification: To 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending invastigation 1 ANatural after death. 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Piace of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 - Homicida To the Hospital of within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. Licansa number t w 10 cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura AUG 0 7 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent'e Name (First, Middle, Last) 2. Dete of Death **Physician** Doerk arole 4b. City, Town, or Location of Death 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner re City 7. Age (In yis. last birthdey) JOHNS TODKIN. If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months Deys Hours 1 M STYF 579-62-6215 62 Yrs Director Maryland Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limite 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 20No Director P.G. Forestville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 8 8002 Jordon Park Blvd 238 20747 United States Funeral filed within 72 hours after death 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☐ Merried 1 Yes 25 No If Yes, Give 6 Baltimore, Maryland 21215-0020 1□ Yes 25 No White Specify Aq 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Hame Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file gepartment of Health and Mental Hy important: if Item 27 is marked oth any Injury or other traumatic even pnbs. John J. Lehman Alice M. Klotz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6338 Northbrook Drive, Dunkirk, Maryland 20754 Patricia VanWie (SISTER) 20a. Method of Disposition

1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) Aug 8, 2000 20c. Location - City or Town, Stata Washington National Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 allel 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart faiture. List only one cause on each line. Onset end Death Physician tmmediate Cause (Finat disease or condition resulting in death) /Medical Examiner Due to (or as a consequenca of) Physician/Medical Examine Hodom nal wound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): 68760 Endometrial cancer d years Due to (or as a consequenca of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were autopey findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed besity 1 Yes 2 No 1 Yes 2 No Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident after death Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide 8 To the Funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinton, death occurred at the time, date end place, end due to the cause(s) end manner stated. Medical 29e. Certifier 4 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier August 4 rogan MD RES-000 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 21387 -

Registrar DHMH 16 Rev 6/95

State

Street

9106

600 North Wolfe

32. Registrar's Signature

Grogan

AUG 0 8 2000

Kelly

31. Date filed (Month, Day, Year)

WILLIAM

DAVAGE

State of Maryland / Department of Health and Mental Hygiene

/	Department of Health and Menta	пудіене	
	Certificate of Death	Reg No	

Physician
/Medical
Examiner

1. Decedent's Nama (First, Middla, Last) William G. 2. Date of Deeth Month

3. Time of Death

4a Facility Neme (If not institution, give street and number) MARLBORO PIKE AND WEBER DRIVE

6. Sex

AUGUST 4b. City, Town, or Location of Death 4:30P.M.

Funeral

28a-f ahow

Nerna 23a or

filed within 72 hours after death

5. Social Security Number 1√2 M 2□ F 212-66-4279 Usual Residence of Decedent

7. Age (In yrs. last birthday) 44 Yrs.

DISTRICT HEIGHIS # Under 24 Hrs. 8 Date Min. Days Hours March 31,

PRINCE GEORGES 8 Date of Birth (Month, Day, Year) 1956

4, 2000

4c. County of Death

Day

9. Birthplaca (State or Foreign Country) Cheverly, Md.

t0d. Inside City Limits

Director

7 is marked other than "natural", or items 23s or 28s-f shor traumstic avent, the Madical Examiner must be notified at Director Funeral þ Completed

Be

10e. Stete 10b. County Maryland Prince George's

Mitchellville

10c. City, Town or Location

10f. Zip Code 20721

1 Vas 2 □ No 10g. Citizen of What Country?

10e. Street and Number

12311 Kings Valley Ct. 1 Nevar Married 2 ☐ Married

12. Wes Decedent Ever in U,S. Armad Forcas? 1 Yes 2 No If Yes, Give X Yaar or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1 Yes 2 No Specify:

14. Reca - American Indien, Black, Whita, atc. Specify: Black

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Collega (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

United States

12 17. Father's Name (First, Middle, Last)

Carpenter 18. Mother's Nama (First, Middle, Maiden Sumame)

Private

Russell Davage

19a. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Berlyn B. Brooks

Akia Newman Moses/ Daughter 20a. Method of Disposition

20b. Place of Disposition (Neme of cematery, crematory or other place)

3160 Westdale Ct. Waldorf, Md. 20c. Location - City or Town, Stata Data Clinton, Md.

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

Resurrection Cemetery 8/11/00

22. Name and Address of Fecility
Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

21. Signeture of Funerel Service Licenses

23e. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

tmmediete Cause (Final disease or condition resulting In death)

Due to (or as a consequence of)

Approximate Onset end Death

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Due to (or es a consequence of)

Dua to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1EXYes 26. Place of Death (Check only one)

1 Ves 2□ No

25. Wes case referred to medical 1 Yes 2□ No

27. Manner of Death 5 Pending Investigation

100

Pert It. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 4:23 pm

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE 28d. Describe how injury occurred to vehicle Driver Fixed Objects that Struck

2□No

29a. Certifier

29b. Signat

1 Naturel

2 Accident

3 Suicide 4 ☐ Homicide

28e. Flece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the cause (S) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause (s) and menner steted. 29c. Licanse number 29d. Dete signed (Month, Day, Year)

State

Registrar

address of person who completed cause of death (Item 23a) (Type, Print) 30. Nagle an

O.C.M.E.

AUGUST 5,2000

6

31 Date field (Mont) Dey, Year) AUG 0 9 2000 Ogneras

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

Saltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be file Department of Health and Mental Hys Important: If flem 27 is marked othe any Injury or other traumatic avent, phose.

Physician

/Medical Examiner

ed by the attending physician and detached for use as the bunal-transit

ata has been signed by page 2 should be detac

After this certificate has

p

Completed

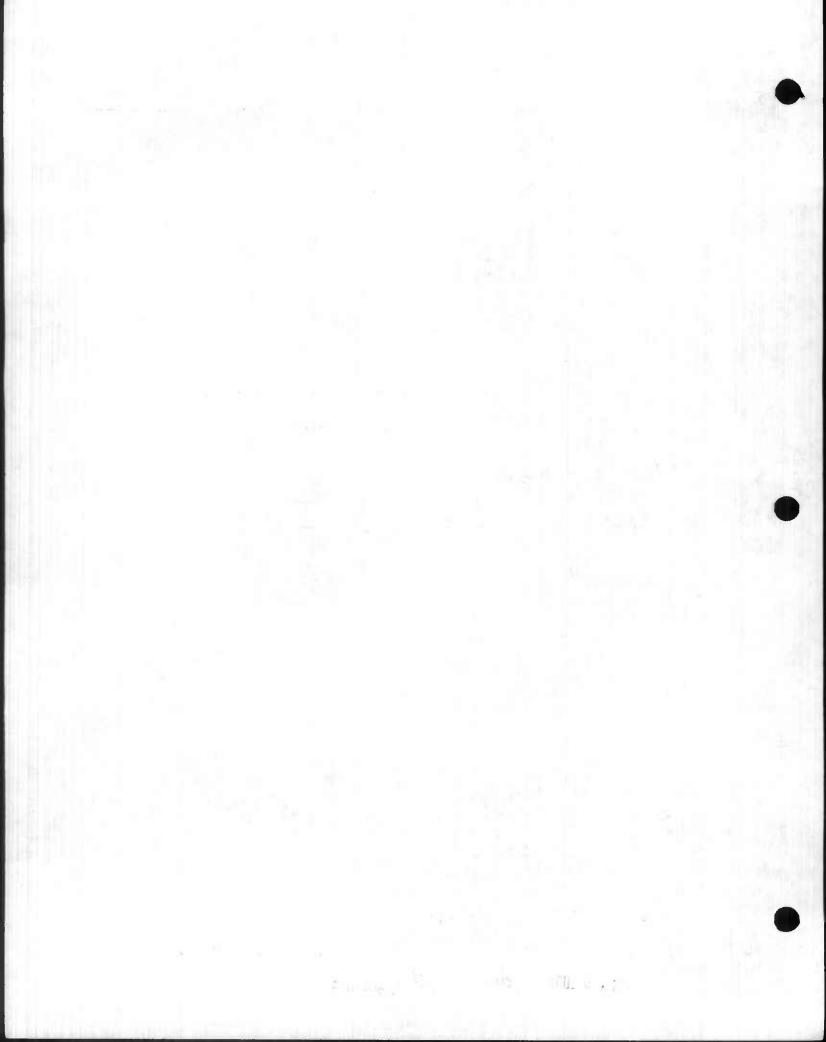
Be

Certification: To

Medical

The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Physician:



State of Maryland / Department of Health and Mental Hygiene 00 26713

			Certificate o	f Death	F	Reg. No.	20113			
Discolation	1. Decedent's Nama (First, Middle, Las				2. Data of Dea		3. Time of Death			
Physician /Medical	Callie Dicke	ens Draughi	n		August	7°, 2000	7:15 AM			
Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	4c. County of	Death			
4	Independent Livi	ng		Hyattsvi			George's			
Funeral Director	5. Social Security Number 6. St 578-56-9997	ex	Yrs. If Under 1 Yas Months Day			Year) 1, 1909 N	Birthplace (Stata or Foraign Country) Forth Carolina			
2 .	Usual Residence of Decedent	10-02-7-								
er death with the Maryla Herra 23s or 28e-f show her must be notified at Unnersi Director	District of Col		nington				10d. Inside City Limits 1 XYes 2 No			
or 28e-f	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?				
at 23s	4116 - 3rd Stree	et, N.W.	2001	.1		United	States			
21215-0020 d within 72 hours after despises. r than "natural, or hems the Medical Examiner in	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yas, specify Co	uban, Maxican, Puer	Specify Yas or No- to Rican, atc.)	ecity Yas or No- Rican, atc.) 14. Race - American In Black, White, atc. Specity: Blace				
72 hou	15. Decedent's Ed	ucation 16	Sa. Decedent's Usual Occ	upation		16b. Kind of Busin	nass/Industry			
21215-0 ed within 72 hr ygiene. er than 'natur t, the Medical Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Giva kind of work dor lifa. DO NOT use reti	ne during most of wo red)	rking					
d will	twelve years	College (1-401 5+)	Housewife			Privat	e			
land id be file ental Hyperal seems of the ental Hyperal seems of the ental seems of the	17. Father's Nama (First, Middle, Last) Henry Dickens				ma (First, Middle, se Cherry	Maiden Surnama)				
Mary of 2 show th and M 7 is mary trauman	19a. Informant's Name/Relationship (7 Irma Jean Draugh		9b. Mailing Addrass (Stre T 636 Farad							
OF THE STATE OF TH	20a. Method of Disposition	20b. Place	of Disposition (Nama of		Data	20c. Location - Ci				
L Pages ment of h	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Ham	nony Memoria	l Park 8	3/12/2000	Landov	er, Maryland			
Departiment in portion any in	21. Signature of Funeral Service Ligen	C. Vo. AW	22. Nama and Add				ome. Inc. n, D.C. 20019			
	23a. Part Level the disease, or comp shock, or near failure. List only of	lications that caused the death. Done cause on each line.					Approximata Intarval Between Onset and Death			
Physician /Medical Examiner	Immediata Cause (Final disease or condition resulting in death)	a. Cardio pul Due to (or as Due to (or as	wave a	rrest			years			
2 2		sviti2200)	Lent S	sulies			nears			
oxecuted in end fel-transit	Sequentially list conditions,	Due to (or as	a consequence of):				9 313			
E SE X	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events	is chamic	cardio		Also		1			
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OT VITAL RECORDS, P. Physicien: The law requires that this certificate has been signed b all director, page 2 should be deter- TO Be Completed by Pl					24a. Wss o	an autopsy med?	24b. Wara sutopsy findings sysilable prior to completion of cause			
The law requirements page 2 should Completed				466.	10 Y	as 2 No	of death?			
VITAL licien: The certificate rector, par	25. Was case referred to medical			26. Place of De	ath (Check only o	na)				
Physicien: This certification of the control of the	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/O	Outpatient 3 DOA	Nh an			(Specify) Group Home			
ding Phy in. Afterthia funeral c	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b	. Tima of 28c. In Injury		_	ow injury occurred				
r Atten terdes irector n by the	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined		farm, street, factory, office	96	28f. Location (S City or Tow	Street and Number m, Stata)	or Rural Routa Number,			
Hosph 24 hour Funer tely fill		reiclan: To the best of my knowled- iner: On the basis of axamination a								
within 2 To the comple	29b. Signature and Mile of certifier	and manner stated.	200 Line	nse number		29d. Data signed (Month Day Year)			
5 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	255. Signature and an order	5 /				O / \	month, bay, reary			
6	aya 1	1. Jan 19	ME	14975		8/8/0	υ			
4)	30. Name and address of person who c	completed cause of death (Item 23a		osylvan	or A si	NW 1	Worling & De			
State Registrar	31. Date filed (Month, Day, Year) ALIG 0 9 2000	82. Registrar's Signature	los d							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amended Item	5 perFHG789 11/		W	waryian		tificate of	Death		Reg. No.	0 2	6714			
Physician /Medical	Decedent's Name (Firs	t, MAJORE, LIEST		A. Del	homme			2. Date of De Month August	3, Day 2000		:45AM			
Examiner	4a Facility Name (If not in Charles Cou						4b. City, Town, or L La Plata	ocation of Deat						
Funeral Director	5. Social Security Number 215 - 28 - 9019 215 - 28 - 9019	6. Se	K 7.	Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, De May 2.5	Charle		(State or Foreign			
nytand those	Usual Residence of Dece 10a. State 10b.	County		10c. City	y, Town or Loc	cation					Inside City Limits			
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With a	10e. Street and Number					10f. Zip Code			10g. Citizen of \	Vhat Country?				
ma 23	11819 Adria	n Lane	12. Was Decede	ent Ever in U.	S. 13. V	20646		pecify Yes or No	USA No- 14. Race - American Indien,					
1 28 5	1 Never Married 2		Armed Force 1 [3] Yes 2 If Yes, Give	ne?	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W Specify: W									
Maryland 21215-0020 22 should be fled within 72 hours at hand Mental Hygiene. I hand marked other than "natural", or traumatic event, the Medical Exemptrometic event, eve	(Specify onl	ecedent's Edu y highest grad (0-12)		or 5+)	(Give I life. D	ia. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) MUSICIAN			16b. Kind of Bu					
d Hygin	12th 17. Father's Name (First,	Middle, Last)			Musi	clan	18. Mother's Nam	e (First, Middle		ny Band				
riand be in the state of the even	Alcide Del	homme					Elmir	e Unkr	nown					
fary and N	19a. Informant's Name/B	ant's Name/Relationship (Type, Print) J. Delhomme/Son 19b. Mailing Address (Street and Number or Run Same as item 10						ral Route Numb	er, City or Town,	State, Zip Coo	10)			
e, N	Alan J. Del		on	004 0			item 10			01 7				
Limor Liment of bush of bush of bush of bush	20a. Method of Disposition 1 Description Burial 2 Crem 4 Donation 5 C	nation 3 R		. 0	emetery, crem SUTTEC		etery 8/8		20c. Location - Clinton	, Maryl				
Banyle	21. Signature of Funeral S	Service Licens	es f				kalas Fur Hill Rd.							
1 2 2	23a Fart1. Enter the dise	e: List only or	cation, that cau	sed the death h line.	n. Do not ente	r the mode of dyi	ng, such as cardiac	or respiretory a	rrest,	Inte	proximete ervel Between set and Death			
Physician /Medical	Immediate Cause (Final		Contr	io Ada	22222	inomo				- One	set and Death			
Examiner	disease or condition resulting in death)		Gastr	OV	nocarc					1				
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	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
P.O. Box at the death certification of the attending stached for use Physician/M	Part II. Other significant of	It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death				
requires that the de- sen signed by the a hould be detached i								10	Yes 2□ No	3 Probabl	y 4 🔀 Unknown			
aw requires been a 2 ahould pleted				75					an autopsy ormed?	availab	autopsy findings ble prior to ation of cause th?			
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Vital I eiclen: The certificate lirector, per	25. Was case referred to examiner?		loenital:			low	26. Place of Dea	th (Check only	one)					
大 神 神 上	1 ☐ Yes ②☐XNo 27. Manner of Death		ospital: 1 Inp	1	ER/Outpatient 28b. Time of	3LI DOA			dence 6 Oth					
ding After	7777	Pending investigation		Day Year)	Injury	Wo	rk? Yes 2 □ No	20d. Describe	now injury occur	ed				
Division of the or attending Practice. After the or by the funeration: Certification:		Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Aural Ro	ute Number,			
To the Hospital or minin 24 hours after to the Funeral Dir completely filled in Medical Cerr	29a. Certifier 1 TC C (Check only 2 M	ertifying Phys edical Examin	ician: To the be ier: On the basis and manner	of examinat	wledge, death ion and/or invi	occurred at the ti estigation, in my o	me, date end place, ppinion, death occur	and due to the red at the time,	cause(s) and me date and place,	enner as stated and due to the	1. cause(s)			
W W	≥ 29b. Signature and title of tertifier 29c. License n								29d. Date signe		Year)			
(in)	Aul Catin mm D53592						92	8/3/2000						
(10)	30. Name and address of Arnel Castr						Suite 100	Waldor	f, Md. 2	0602	16.418			
State Registrar	31. Date filed (Month, Day	Year)		istrar's Signal										

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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niner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or 3601 GALLATIN STREET APARIMENT # 722 HYATTSV																	FIC
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	-	el Residence																
tor	Maryland Prince George's 10c. City, Town or Location Hyattsville											10d. Inside City Limits 1 ☒ Yes 2 ☐ No						
Director	10e	10e. Street and Number 10f. Zip Code											10g. Citizen of What Country?					
		3601 Gallatin St., #722 20782										United States						
by Funeral		Marital Status Never Me Widowed	ried	12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuben, Mexican, Puerto 1□ Yes 2 ☼ No Specify:							ck, White,	American Indian, White, etc. Black		
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32. Registrar's Signature

DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

ALC WAS

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mul Lay , HRISTOPHE AUGUST 2000 /Medical 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health HEARTIAND t Under 24 Hrs. 8. Date of Bir Hours Min. (Month, De P.G LARC If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2KF Days 224-26-1307 85 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at Ves 2□No Shingto Director DIC 10e. Street and Number 10g. Citizen of What Country? 10f. Zlp Code | RANdy WINE State | 12-Wes Decedent Ever in U.S. Armed Forces? | 1 | Yes 2 | No If Yes, Give Yeer or Dates: ST.S.E U.S.A. 680 20032 Funeral 7 is marked other than "natural", or items treumstic event, the Medical Example of 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 KNo Specify: by Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) own home Domestic 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be SARA MOORE 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a: If Item 27 is or other tre Rice Mas Millie oleherne BAltmore Md. 21229 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury o once. 8/7/00 WAShington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Glenwood 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5732 Georgin Aue. N. W. reliend House of Williams WAShington DL ZOUII 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervai Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Hennic disease or condition resulting in death) Examiner Due to (or as a consequence of): IRRhosis physician and the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Dua to (or as a consequenca of) Hepatitis Physician/Medical Due to (or as e consequence of): USB AS attanding | for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be detached 23b. Did tobacco use contributs to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown decub, tosulcel p 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy performed? Completed ANTHOLCLOROTE CARDIOVALWIAN Disease cartificata 2 0 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel examiner? 1 ☐ Yes 2 No director. Be 26. Piace of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) funaral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Netural 5 Pending Investigation i or Attending s after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end piaca, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier Medical 29b. Signature and title of certifier 290-license number DOISS

To the Hospital on within 24 hours aft

this

tha Maryland

filed within 72 hours after death with

Hygiene.

Pages 1 and 2 should be Innent of Health and Mental

requires that the death certificate be

Division of Vital

Baltimore, Maryland 21215-0020

State

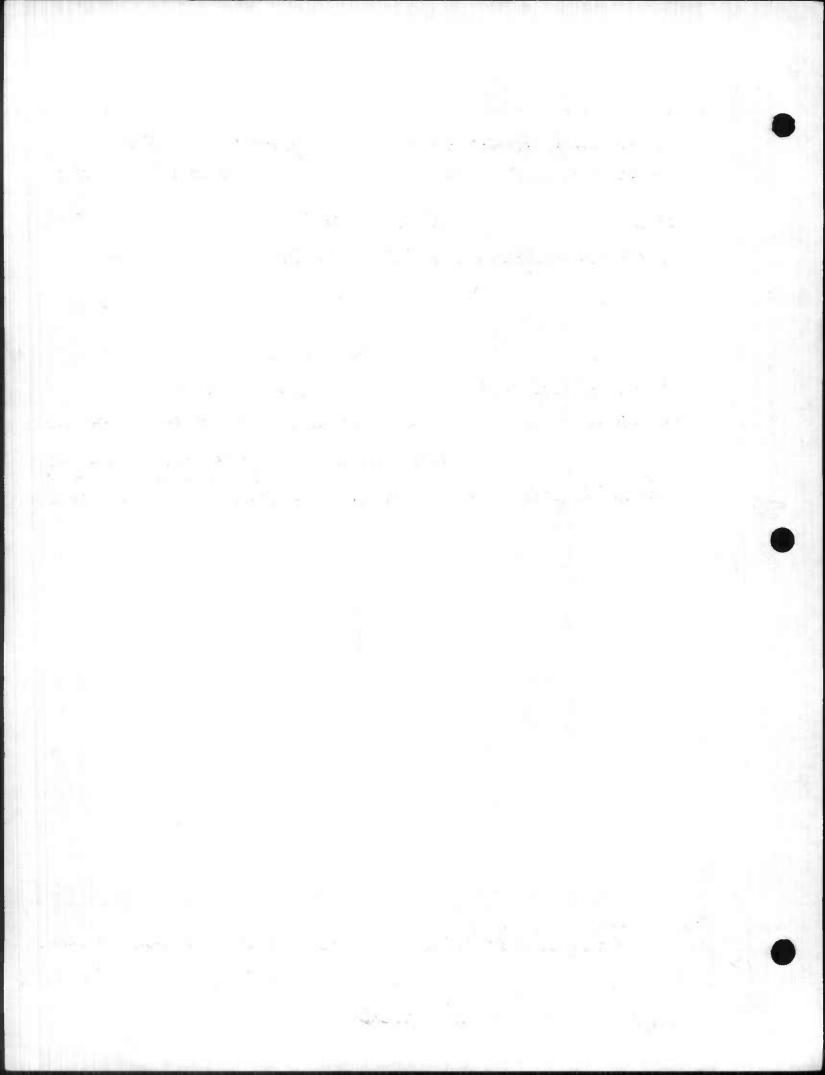
Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Dey, Year) 0 7 2000

PORE MD 4203 EXUENSBURY Rd HYSTTEVILE MD 20181

29d. Date signed (Month, Day, Year)

AVEUST 3 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST Physician 12, 2000 3:10 PM ERNEST ALEXANDER DUCKETT /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES GLADYS SPELLMAN NURSING HOME CHEVERLY 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours MARYLAND 212-14-3885 85 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow | 1 ☐ Yas 2 XNo natural, of flams 23s or 28s-f oficial Examiner must be notifie Directo MARYLAND CHARLES LA PLATA 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 UNITED STATES 10776 LA PLATA ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARETAKER PRIVATE 6TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 is marked of LILLE ROBINSON DUCKETT ZEBRA DUCKETT permit. Pages 1 and 2 ah. Department of Health and Important: If them 27 is man Any injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10776 LA PLATA ROAD, LA PLATA, MARYLAND AGNES B. DUCKETT / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ol Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal Irom State TRINITY MEMORIAL GARDENS 8/19/00 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
THORNTON FUNERAL HOME, P.A.
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640
Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laiture. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical tmmediate Cause (Finat · CHRONIL OSSTAUCTIVE LUNG -Rapus disease or condition resulting in death) Examiner Due to (or as a consequence ot) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yea 2 No 3 Probably 4 nonknown Kespiratory failure / ventilator Records, þ 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (ANatural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, Iarm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

State Registrar

(Check only one)

29b. Signature and title of certifier

ORE MO 31. Date liled (Month, Day, Year) 32. Registrar's Signature AUG 1 5 2000 Deneva

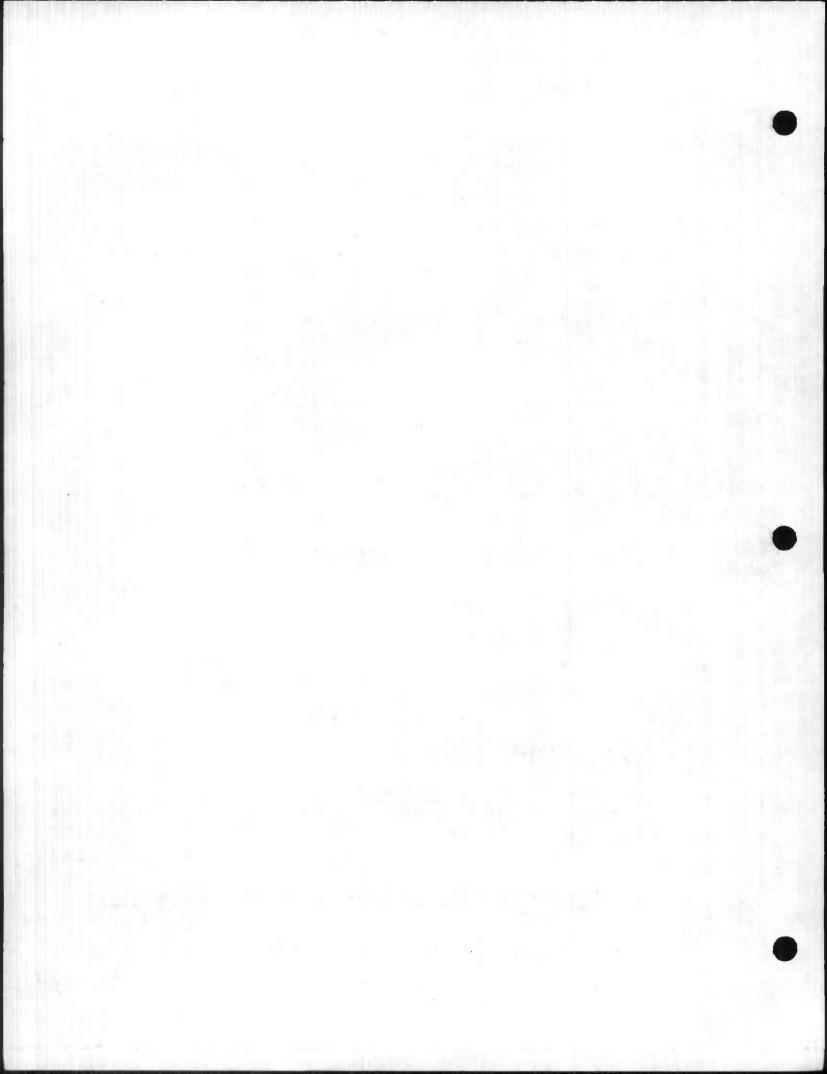
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4203 Queensbuy Rd Hyattswille Mets 20287

292 License number

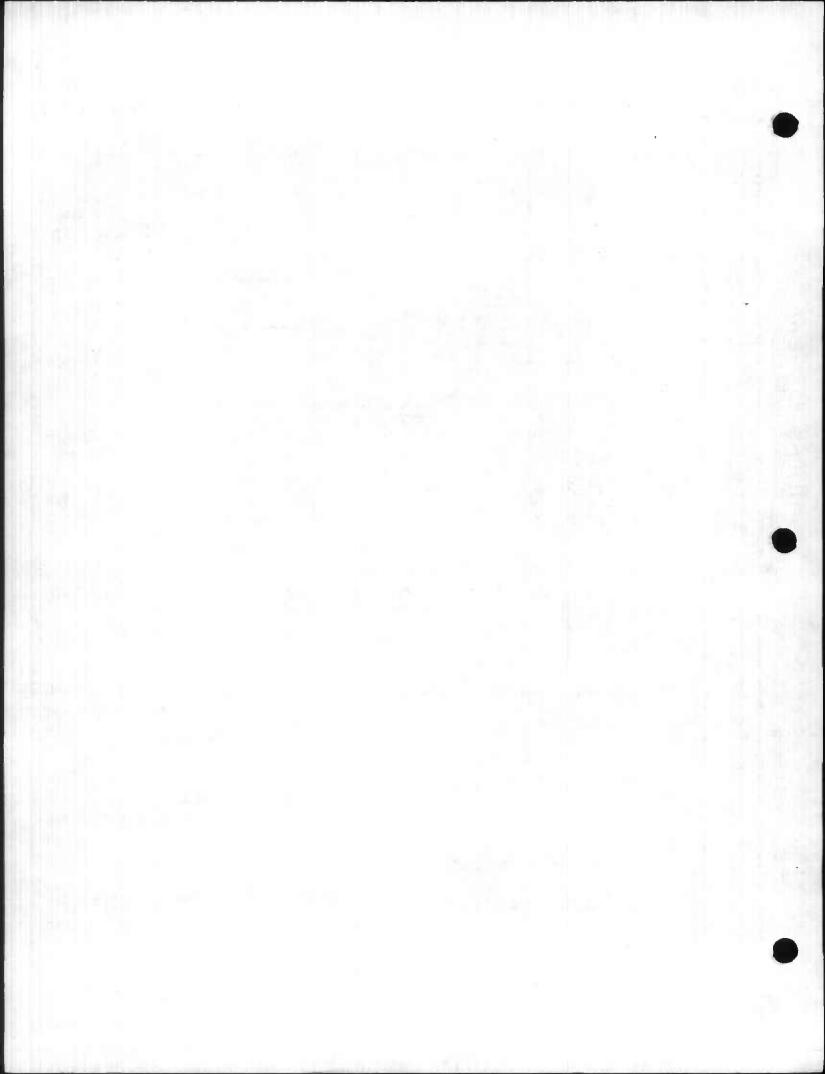
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29d. Date signed (Month, Day, Year)



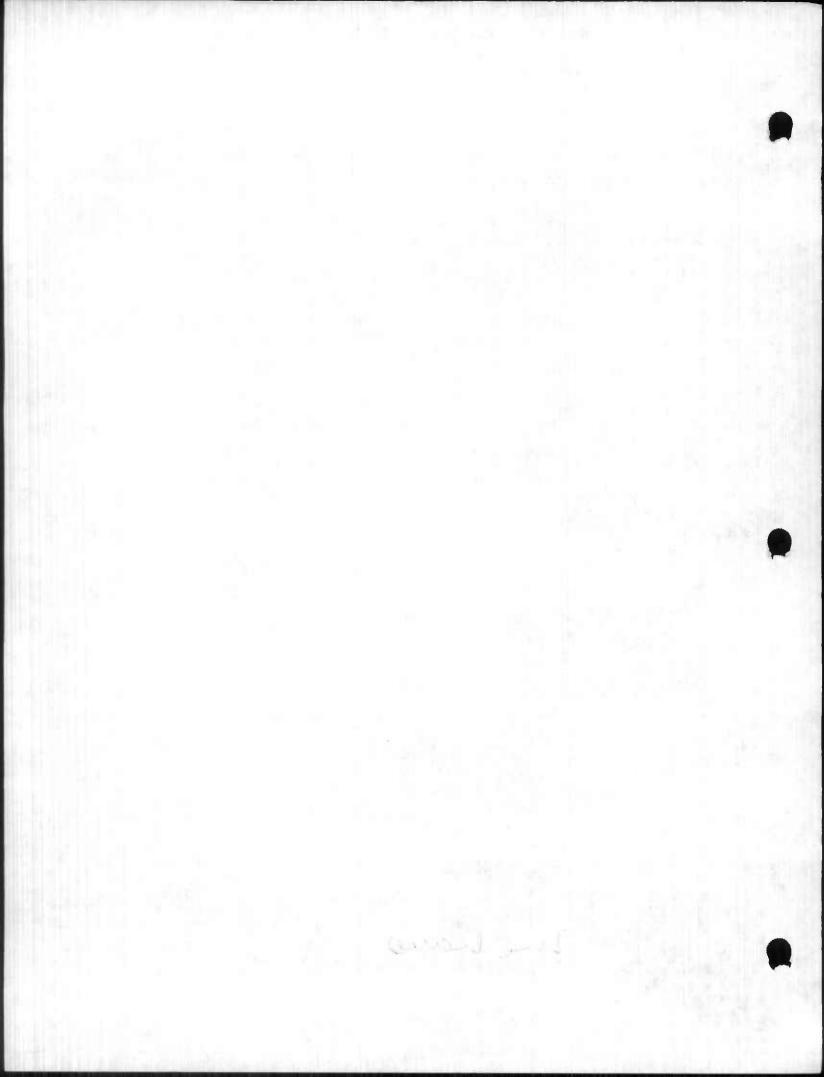
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

	1. Decedent's Nama (First, Middla, Last)								2. Data of D			. Tima of Death		
ysician	MARY LU	CILLE LEV	IS DYSON						A U G U	ST 13 2	Year	:17A.M		
ledical aminer		(If not institution, given					4b. City, Town, or Location					. 1 / A . M		
	CIVISTA	A MEDICA	L CENTE	C.R			114	LA PL	ΔΤΔ	СНА	RLES			
al	5. Social Sacurity I	Number 6.	Sax 7.		. last birthday)		er 1 Year	If Under 24 Hrs				(State or Forei		
or	217-14- Usual Rasidence of	7995	I□M 20ÅF	78	Yrs.	Months	Days	Hours Min	8. Dala of B (Month, D OCT.	2, 1921	MARYLA	(State or Forei		
rector	10a. Stata	10b. County			ity, Town or Lo	cation						Inside City Limit		
octo	MARYLAND		3	LA	PLATA							IZUTAS ZUN		
Director	10e. Street and Nu					10f. Z	ip Code		100	10g. Citizen of \	What Country?			
		E HILL RO	· · · · · · · · · · · · · · · · · · ·				206			UNITED				
by Funeral	11. Marital Status 1 ☐ Never Men 3 ☒ Widowed	riad 2 Married	12. Was Dacede Armed Force 1 Yas 2 If Yes, Give Yaar or Date	es? Mo				Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yas or N to Rican, atc.)	Specify	e - American II ck, White, etc. y: BLACI			
ted	/Sne	15. Decedent's E	ducation		16a. Deced	ent's Us	ual Occup	pation during most of wo	dina	16b. Kind of B				
Completed	Elamantary/Sec		Collega (1-4	or 5+)	lifa. C	NOT .	use retire	d)	rking					
Co	12TH GRA				HOU	SEWI	FE				MAKING			
Be	17. Fathar's Nema	(First, Middla, Last						18. Mother's Ne	me (First, Middle	e, Maiden Suman	ne)			
1º	MILFORD									ON LEWIS				
		lame/Ralationship	**		10 A A A A A A A A A A A A A A A A A A A			and Number or R						
		DYSON / SO)IN					COURT, W						
H	20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or camatary, crematory or other place) ST. JOSEPH'S CHURCH CEM. 8/17/00 POMFRET, I													
	22. Nama and Address of Facility THORNTON FUNERAL HOME, P.A. 1. VOIA C. THORNTON JOINSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20 239. Part First the disease or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory errest.													
	23a. Part1. Enter tha disaasa, or complications that causad tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximeta Interval Between Onset and Death													
cai Examiner	Immediata Causa (Final disaasa or condition resulting in death) e. **Due to (or es a consequence of):** Due to (or es a consequence of): Cotomary Hand Dusses Due to (or es a consequence of):											as		
Physician/Medic	thet initiated avents rasulting in death) Lest Dua to (or as a consequence of):													
Sic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributions.											cause of deal		
by Phy	1□ Yes 2∰1										3 Probabl	y 4 Unkno		
Completed b	24a. Was an autopsy performed?								availab	autopsy finding ble prior to etion of cause h?				
O.									10	Yas 20N6	1 ☐ Ya	s 2 No		
Be	25. Was casa rafai	rred to medical						26. Place of De	eth (Check only	one)				
2	1 ☐ Yas 2 ☐	No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	300	OH OH	her: 4 Nursing 1	loma 5□ Res	idence 6 Oth	er (Specify)			
	27. Mennar of Deat 1 ☑ Netural 2 ☐ Accident	th 5 Pending Invastigetion		njury Dey Year)	28b. Tima of Injury	М	28c. Injui Wo	ry at rk?] Yes 2 □ No	28d. Describe	how injury occur	red			
atio	3 Suicida 6 Could not be determined 28a. Placa of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Numb City or Town, Stete)									(Street and Numb wn, Stete)	oer or Rural Ro	ute Number,		
Certification		,												
dicai Certification:	4 ☐ Homicida 29a. Cartifiar	1 Certifying Ph	ysician: To the be niner: On the basis and manner	s of axamin	owledge, death ation and/or inv	astigation	n, in my c	opinion, deeth occi	rred at tha time	cause(s) end ma , date and piece,	and due to the	cause(s)		
Medicai Certification	4 Homicida 29a. Cartifiar (Check only	2 Medical Exar	niner: On the basis	s of axamin	owledge, death ation and/or inv	astigation	n, in my c	opinion, deeth occi	urred at tha time	cause(s) end ma , date and plece, 29d. Date signe	and due to the	cause(s)		
edicai	4 Homicida 29a. Cartiliar (Check only one)	2 Medical Exar	niner: On the basis	s of axamin	owledge, death ation and/or inv	astigation 29	n, in my c	se number	irred at tha time	, date and plece,	and due to the	cause(s)		
edicai	4 Homicida 29a. Cartiliar (Check only one)	2 Medical Example of certifier	niner: On the basic	s of axamina stated.	ation and/or inv	astigation 29	n, in my o	se number	, and due to the	, date and plece,	and due to the	cause(s)		



State of Maryland / Department of Health and Mental Hygiene 0 0 26719

				Ce	ertificate c	of Death	7	Reg. No.	20115					
	U. I. I.	1. Decedent's Neme (First, Middle, La	sf)					of Deeth	3. Tima of Death					
	Physician	Rodney Gray D	arneille				Augu	th 1, 2000	4:35P.M.					
	/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)	0.000		4b. City, To	own, or Location of	Deeth 4c. County	of Death					
1	Examiner	Suburban Hospital		esda	Montg	omery								
-	Eunoval	5. Social Security Number 6. S		In yrs. last birthday) If Under 1 Ye	er If Under		of Birth oth, Day, Year)	Birthplaca (State or Foreign Country)					
ш	Funeral Director	578-10-8759	XM 2□ F	91 Yrs.	Months Da	ys Hours	Min. (Mor	22. 1908	Washington, D.C.					
	_	Usual Residence of Decedent					1000.	22, 1900	washing con, D.C.					
	Nanc Nanc	10a. Steta 10b. County		Oc. City, Town or I	Location				10d. Inside City Limits					
	to feet	Maryland Montgo	merv	Kensing	ton				1 ☐ Yes 2 No					
	128 LINE	10e. Street and Number			10f. Zip Cod	0		10g. Citizen of V	Vhat Country?					
	inter death with the Maryland r floms 23s or 28s-f show virer must be notified at Funeral Director	9815 Hillridge Dr	ive			20895		United	States					
	The 2	11. Marilel Sielus	12. Was Decedent Ev	er in U,S. 13			rigin? (Specify Yes in, Puerto Rican, e		e - American Indien,					
0	F. F.	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No					ic.) Biac	k, White, etc.					
21215-0020	be filed within 72 hours after death with the Marylar tal Hyglene. d other than "natural", or items 23s or 28s-f show event, the Wedical Examiner result be notified as event, the Wedical Examiner result be notified. Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1□ Yes 2∏	No Specify	<i>"</i> :	Specify	White					
ō	Phone Phone	15. Decedent's Ed	ducation	16a. Dec	edent's Usual Oc	cupation		16b. Kind of Bu	siness/Industry					
215	ple co	(Specify only highest gra Elemantary/Secondary (0-12)	college (1-4or 5+)	(Grv life.	e kind of work do DO NOT use re	ne dunng mos tired)	st of working	Repub1	ic Powdered					
21	Para Para Para Para Para Para Para Para	Elemantary/Secondary (0-12)	2		es Repre	sentat:	ive	_	etals					
D	be filed within 72 ho tal Hyglena. d other than "naturi event, the Modical Be Completed	17. Father's Neme (First, Middle, Last,)	4		18. Moth	ar's Name (First, I	Middle, Maiden Sumam	e)					
Maryland	Menta Menta Menta Price To B	Hopewell Hebb Dan	rneille ·			Man	ry Canby	Jackson						
ary	N pu	19e. informant's Neme/Reletionship (Type, Print)	19b. Ma	iling Address (Str			Number, City or Town,	Stata, Zip Code)					
Σ	r tre	Patricia T. Darne	ille/Daught	er 1200	O N Nacl	Stree	+ #826	rlington	Virginia 22209					
ē,	T E E	20e. Method of Disposition	zzze/ baugite	20b. Placa of Disj	position (Name of		Date	20c. Location -	City or Town, State					
Ou.	2 = 2 D	1 ☐ Burial 2 ☼ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Montgomery	amatory or other		Augus	000 Bothood	a, Maryland					
Baitimore,	permit. Pages 1 and 2 should be filed within 72 ho many filed within 72 ho many longer of the many and Mental Hyglene. Important: if them 27 te marked other than "nature any Injury or other traumatic event, the Model and Injury or other traumatic event eve	21. Signeture of Fuheral Service Licer					in Robert	A. Pumphrey	Funeral Home					
Ba	Dep Pen	MO1126 Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501												
		1109			Bethesda	, Mary	land 208	14-3501						
	-	23a. Pert1. Effer the disease, or con shock, or heart failure. List only	one cause on aech line	e death. Do not e	nter the mode of	aying, such es	s cardiac or respire	itory arrest,	Approximate Interval Between Onset and Death					
F	Physician								Oriset and Death					
P [®]	/Medical Examiner	Immediate Cause (Final disease or condition rasulting in daath)	a. Pneumo	onia					3 Days					
		rasoning in odam)	D	ue to (or as a cons	equence of):									
	incate be executed physician and is the burial-transit edical Examiner	b .												
	enricate be executed ing physician and as the bunal-transit Medical Examir	Sequentially list conditions, if any, leading to immediate												
90,	cian cian surial	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C.												
68760,	requires that the death certificate be execu- een signed by the attending physician and thould be detached for use as the burial-tra- teted by Physician/Medical Exan	that initieted events resulting in death) Last	Di	ie lo (or es e conse	equence of):									
9 X	Me as	A CONTRACTOR OF THE PARTY OF TH	d											
80	in tend	Ball Market Co.	0.											
0	ed by the attend detached for us	Part II. Other significant conditions of	ontributing to death but	not resulting In the	undarlying cause	given in Part	1. 23	b. Did tobacco use cor	ntribute to the cause of death?					
P.0	Phy t							1 □ Yes 2 No	3 ☐ Probably 4 ☐ Unknown					
Ś	be del					-			T.					
Records,	should leted						248	. Was an autopsy performed?	24b. Ware sutopsy findings available prior to					
CO	3 2 5								completion of cause of death?					
	cate has been s page 2 should							1 ☐ Yes 2 🕅 No	1 ☐ Yes 2 ☐ No					
ta '	nysician: The la his certificate ha i director, page 2 To Be Comp	25. Was case rafarred to medical				26 Plac	e of Death (Check							
>	Attending Physician: In death. ector: After this certific by the funeral director. iffication: To Be (examiner? 1 □ Yes 2 ☒ No	Hospital: 1 ☐ Inpatiant	2 🕅 ER/Outpati	ant 3 00 00	Other:		Rasidanca 6 □Oth	ar (Chacihi)					
ō		27. Manner of Death	28a. Date of injury	28b. Time		njury at Work?		scribe how injury occur						
ou .	After After tion	1 X Natural 5 ☐ Pending 2 ☐ Accidant investigation	(Month, Day)	(ear) Injury		Work? I∐Yes 2∐] No							
S	death ctor: A y the f	3 Suicide 6 Could not b	e Ope Diese of Injur	- At home, ferm, s	streat, factory, offi	ce	28f. Loc	ation (Street and Numb	per or Rural Route Number,					
Division of Vital	all or Attending Prints after death. In Director: After thised in by the funeral Certification: 1	4 Homicide	building, afc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City	or Town, Stata)						
	fille ours	29a. Certifier 1X Certifying Ph	ysician: To the best of	my knowledge des	ath occurred at the	a tima data m	nd place, and dua	to the cause(s) and me	nnar as stated					
- :	within 24 hours after within 24 hours after To the Funeral Dire completely filled in Direct Medical Certification of the Completely filled in Direct Certification of the Completely filled in Direct Certification of the			kamination and/or i					end dua to the causa(s)					
	Me We	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signe	d (Month, Day, Year)					
			nola	and)	D3322	24	Anone	t 2, 2000					
	15		-			23322		114543	- 2, 2000					
		Ram Trehan, M.D.				Post.	evilla V	lowuland 200	052					
							CATTLE, M	aryland 20	332					
	State	31. Date filed (Month, Day, Year)	32. Registrar		Sport	N								
	Registrar	AUG 0 7 20	UU /ST	1.	7									



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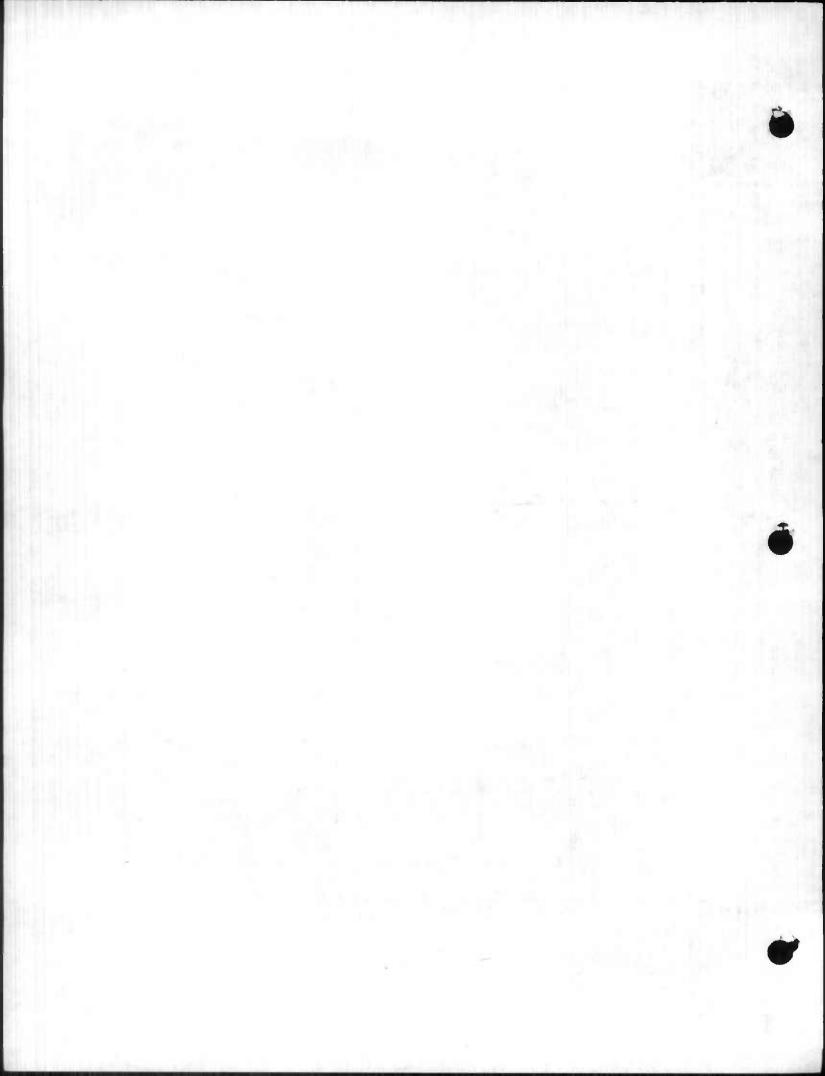
		1 Decedent's	Name (First, Middle, La		ary railor /		cate of	Death		Reg. No.	0 26720 3. Time of Death		
П	Physician				DATIG	037			Month	Day	Yeer		
	/Medical Examiner	An English Ma	MARY me (If not institution, giv	ELEANOR e street end number)	DAWS	ON		4b. City, Town, or I	AUG.	4, 20 h 4c. County			
2	Examine		MANOR CARE	E NURSING HOME PO				POTOMAC		MON	TGOMERY		
	Funeral Director			Sex 7. Ag	e (in yrs. iest 85		Inder 1 Yeer oths Days	If Under 24 Hrs. Hours Min.	8. Data of Bir (Month, De OCT, 2	th	Birthpiace (State or Foreign Country) ILLINOIS		
	anyland	10a. Stete	10b. County		10c. City, T	own or Location	1				10d. Inside City Limits		
	or 28a-f si	MD.	QUEEN A	NNE'S			TILLANC	E			1 ∑ Yas 2 ☐ No		
	with the sor 2	10e. Street an		-		10	f. Zip Code	- (-0		10g. Citizen of V			
	frer death v	11, Menial Ste	12 COLLIER	12. Was Decedent	Ever in U.S.	13 Wes E		1.638 dispanic Origin? (S	pecify Yes or No		S.A.		
020	8 0 E		Married 2 Married	Armed Forças? 1 Yes 2 1 1 If Yes, Give Yeer or Dates:			specify Cub es 2 No	dispanic Origin? (S en, Mexican, Puert Specify:	Rican, etc.)	Specify Specify	k, White, etc.		
9-9	"natural",		15. Decedent's Ed	ducation	1	6a. Decedent's	Usuel Occup	pation	t in a	16b. Kind of Bu			
21215-0020	ed within 72 ho ygiene. her then "natur. ft, tre Medical	Elementery	(Specify only highest gra /Secondery (0-12)	College (1-4or 5	5+)	life. DO N	OT use retire	during most of word)	Killy				
			11				HOMEM		2000 A 4 4 4	14:4:0	HOME		
Maryland	Saby Q		eme (First, Middle, Last)		TOTAL T					, Meidan Sumem			
7	and Mental is merked of sumetic even		EDWARD JO nt's Neme/Reletionship (RELL	19h Meiling Ad	drass (Straat	end Number or Ru	ICY Iral Boute Numb	EDMONST			
Ma	s 1 and 2 should be I Health and Mental tem 27 is marked of other traumatic even	LEA		ER/DAUGHTE				T RD., RC					
re,	of Health of Health of Health of Health of Health	20a. Method o	of Disposition		20b. Piece	e of Disposition	(Neme of		Date		City or Town, Stete		
E	y Tr.		I 2 X Cramation 3 ☐ tion 5 ☐ Other (Specif			AMBERS	CREMA	1	3/7/00	RTVE	RDALE, MD.		
Baltimore,	P. Fridant	21. Signeture	of Funerel Service Licer	rsaa	0112			ess of Fecility	7.17.00	TANK A T			
0	Dep Find Pung	121	MIKA.	mheisel	MO0093	L CHAI	MBERS	FUNERAL H	IOMES .P.	A. SILV	ZO906 ZER SPRING, MD.		
A		23e. Pert1. E shock, o	nter the disease, or com or heart feilure. List only	plicetions that caused one cause on each li	the deeth. D						Approximete Interval Between		
	Physician				1			Λ		. 1	Onset and Deeth		
	/Medical Examiner	Immediate Ca disease or co resulting in de	ndition	. 0	esos	Dya	scu	lar 1	acci	den	- YRS		
ь	to the second		,,		Due to (or as	e consequenc	a of):						
	executed in and ital-transit			b	Type	erre	nsi	M			YRS		
ó			ist conditions, to immediate		Due to (or es	a consequenc	a or):						
68760	ficate be physicial to the bur												
	og physias the	rasulting in da	lath) Last										
Вох	death certification of attending of lor use as			d									
	0 0 0	Part II. Other e	eignificant conditions c	ontributing to death b	ut not resultin	g in the underly	ring cause gi	ven in Pert I.	23b. Dld	tobacco use cor	ntribute to the cause of death?		
P.0	requires that the dependence of the hould be detached								10	Yee 2□ No	3 Probably 4 Unknown		
of Vital Records,	8 88 0		P 1 - 1						24a Was	an eutopsy	24b. Were autopsy findings		
00	been si should									omed?	evailable prior to completion of cause of deeth?		
Re	The law requires the law require page 2 should Completed								10	Yes 20tho	1 ☐ Yes 2 R No		
ta	Certificate rector, pag	25. Wes case	refarred to medical					26. Piece of Dec			10165 244(10		
2				Hospital:	nl 2 ER	/Outpetient 3	DOA OI	her .		idence 6 □Oth	er (Specify)		
	After this funeral d			28e. Dete of Inju (Month, Da	ry Year) 28	b. Time of Injury	28c. Inju	ry at	28d. Describe	how injury occurr	ed		
0	Attending or death. ector: After by the fune liffcation	2 Accid	ent investigation	n		N		Yes 2 No					
Division		3 Suicid		28e. Pleca of Inj building, etc	ury - At home c. (Specify)	, farm, street, fo	ectory, offica		28f. Location (City or To		er or Rurel Route Number,		
	Hospi 4 hou Funer tely till	29e. Certifier (Check on one)		nysician: To the best of niner: On the basis of end menner sto	examinetion						onner as stated. and due to the cause(s)		
	within 2 To the comple	29b. Signatura	a end title of goodle				29c. Licens	sa number		29d. Date signe	d (Month, Dey, Year)		
	2		+AONO	and			1)3.	5792		AUGUS	T, 5 = 2000		
	100	30. Neme end	address of person who	completed cause of d	eeth (Item 23	le) (Type, Print)		70					
		SWA	Roop. 6.1	(AO: 30	, W . E	=DM0	NSTO	ON DK,	KOCKI	IILLE	MD.20852		
	State Registrar	31. Dete filed	(Month, Dey, Year)	32. Registr	er's Signetura		book						

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I Hygiene	00	2672
Die Me		

	Certificate of Death	7	Reg. No.	20121									
H. U.L	Decedent's Name (First, Middle, Last)	2. Dete of E Month		3. Time of Deal									
Physician /Medical	Evelyn D. Doane		t 5, 2000	11:30 A									
Examiner	4a Facility Name (If not institution, give street end number) 4b. City, T	own, or Location of Dec	ath 4c. County of	Death									
	203 Nimitz Avenue Rockv	ville	Montgo	omery									
Funeral Director	5. Social Security Number 414-52-4319 6. Sex 1	Min. 8. Date of E (Month, I August	21, 1935	B. Birthplace (State or For Country) Cennessee									
	Usual Residence of Decedent												
ahow dan	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Li									
deeth with the Maryland ms 23s or 28s-f show Linust be modified at neral Director	Maryland Montgomery Rockville			1 ☑ Yes 2 □									
or 28a-f	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?									
23a c	203 Nimitz Avenue 20851		United S	tates									
r items 23streem vicer must.	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic O If Yes, specify Cuben, Mexica	rigin? (Specify Yes or I	No- 14. Raca	American Indian,									
Hygiene "netural", or its ent, the Western Exercitive But, the Western Exercitive Completed by Fu	1 Never Merried 2 Merried 1 Yes 2 No fit Yes, Give Year or Dates:		Specify:	White, etc. White									
Par I	15, Decedent's Education 16e. Decedent's Usual Occupation		16b. Kind of Busi										
ygiene. ser than "naturi ft, fre Medical	(Specify only highest grade completed) (Give kind of work done during mo	st of working											
Hygiene. oth, the Me	Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker		Own I	lome									
	17. Father's Name (First, Middle, Last) 18. Moth	ner's Name (First, Midd	le, Maiden Sumeme,										
and Mental la marked or raumetic av	Paul H. Newbern Mab	el Tipton											
and Mental	19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numi	ber or Rural Route Num	ber, City or Town, S	tete, Zip Code)									
and 2 should be sellth and Mental and 27 is marked one traumatic av	Donna L. Mack/Daughter 18042 Chalet Dr.#1												
Health Hem 27	20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place)	Date	1	ity or Town, State									
nent of int: If It iry or o	1 Burial 2 Coremation 3 Removel from State 4 Donation 5 Other (Specify) Aug. 8, Montgomery Crematorium, Inc.												
Department of important: If it any injury or o	21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, In 300 West Montgomery Avenue Rockville, Maryland 20850-2805												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	yland 208	50-2805	Approximate									
Examiner ju	disease or condition resulting In death) Due to (or as a consequence of): Diabetes Mellitus												
ician end burlet-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury c.	Due to (or as a consequence of):											
ng physical as the	that initiated events resulting in death) Lest Due to (or es e consequence of):												
ettendir for use													
by the stached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			ributa to the cause of de									
y Ph	Hypertension	- 1	☐ Yee 2⊠ No :	3 Probably 4 Uni									
2 66 2	Chronic Renal Insufficiency	24a. W	as an autopsy dormed?	24b. Were eutopsy findi available prior to completion of caus									
has pe 2	Atherosclerotic Cardiovascular Disease	1[Yes 2 [™] No	of death? 1 ☐ Yes 2 ☐ No									
r this cartificate	25. Was case referred to medical 26. Platexaminer?	ce of Death (Check on)	y one)										
this cardire.		Nursing Home 5 12 Re	sidence 6 Other	(Specify)									
After the funeral	27. Manner of Death 1 Natural 5 Pending (Month, Dey Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 2 Accident Investigation		e how injury occurre	d									
rs after death. iii Director: After ied in by the funers Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)		(Street and Number Fown, State)	or Rurel Route Number,									
within 24 hours after To the Funeral Dire completely filled in Dire Medical Certi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date at the control of the												
Me Me		MAKYLAND	29d. Date signed	(Month, Dey, Year)									
- 3 - 0	12: 1.0HJ 1. DIDI	7/	August 7										
- 1	muhall treduct 441	16	nugust /	, 2000									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	Michael R. Fredericks, M.D. National Naval Medic	al Center,	Bethesda,	Maryland 20									
State Registrar	31. Date filed (Month, Dey, Year) AUG 0 9 2000 32. Degistrar's Signature South												

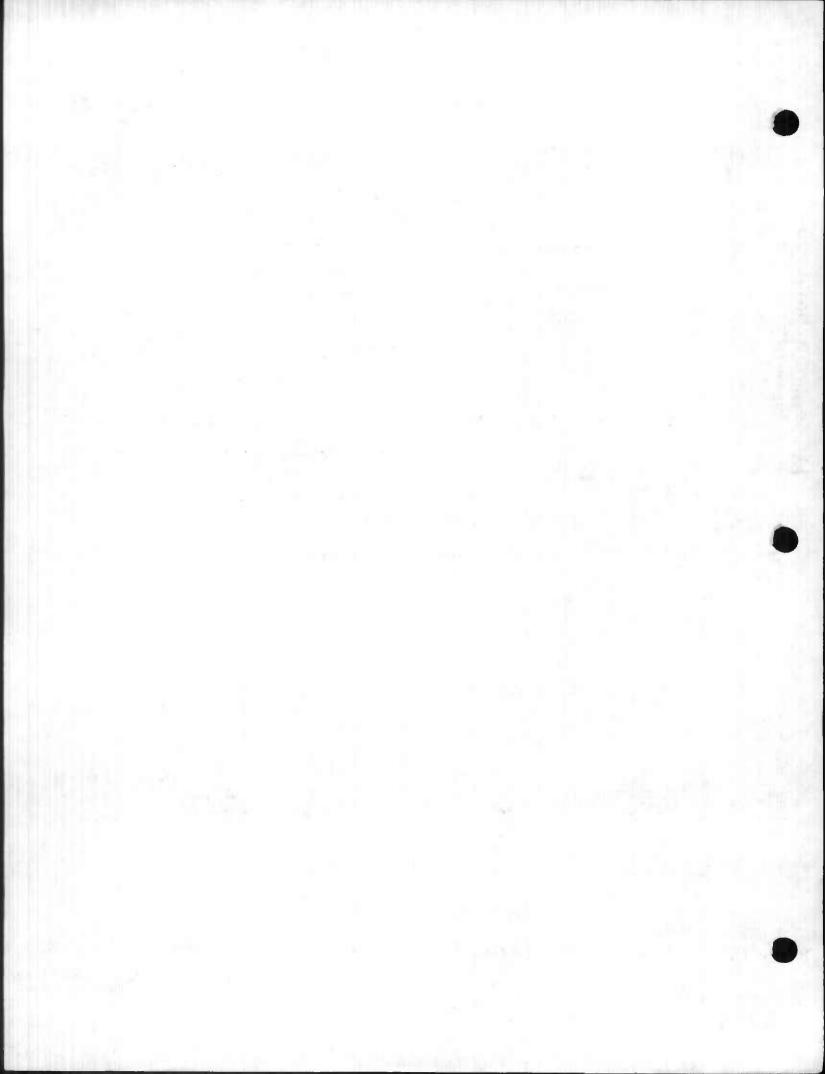


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Day 09 Zax **Physician** 0855 a.M. BARBARA J. DORSEY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Huspital
6. Sex 7. Baltimore aty Baltimore 0+ inai Hours Min. Sept. 16, 1932 9. Birthplace (State or Foreign Country)
Texas If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 25 F 67 457-42-8191 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 21207 U.S.A. 3706 Hillsdale Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Merried Specify: Black 1 Yes 2 XNo Specify. þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montesori School College (1-4or 5+) Elementary/Secondery (0-12) 5+ Administrator System 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Herbert Hudson Jessie Slaughter b 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ē 3706 Hillsdale Rd., Baltimore, MD 21207 John Dorsey (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State Pages ment of 1 ☐ Burial ② Cremation 3 ☐ Removal from State Metropolitan F/Serv. 8/7/00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Ligarises 20850 ROCKVILLE, MD 23a. Pert1. Enter the phease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pancreatic 4 months Examiner Due to (or es e consequence of) Examiner Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 22 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred i or Attending P after death. I Director: After d in by the funen Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner es stated

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16 Kes 000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Hospital of Baltimore 2401 Nest belied weth Sinai Hyensu-Coker m.D. 31. Date filed (Month, Day, Year! 32. Registrar's Signature

DHMH 16 Bey 6/95

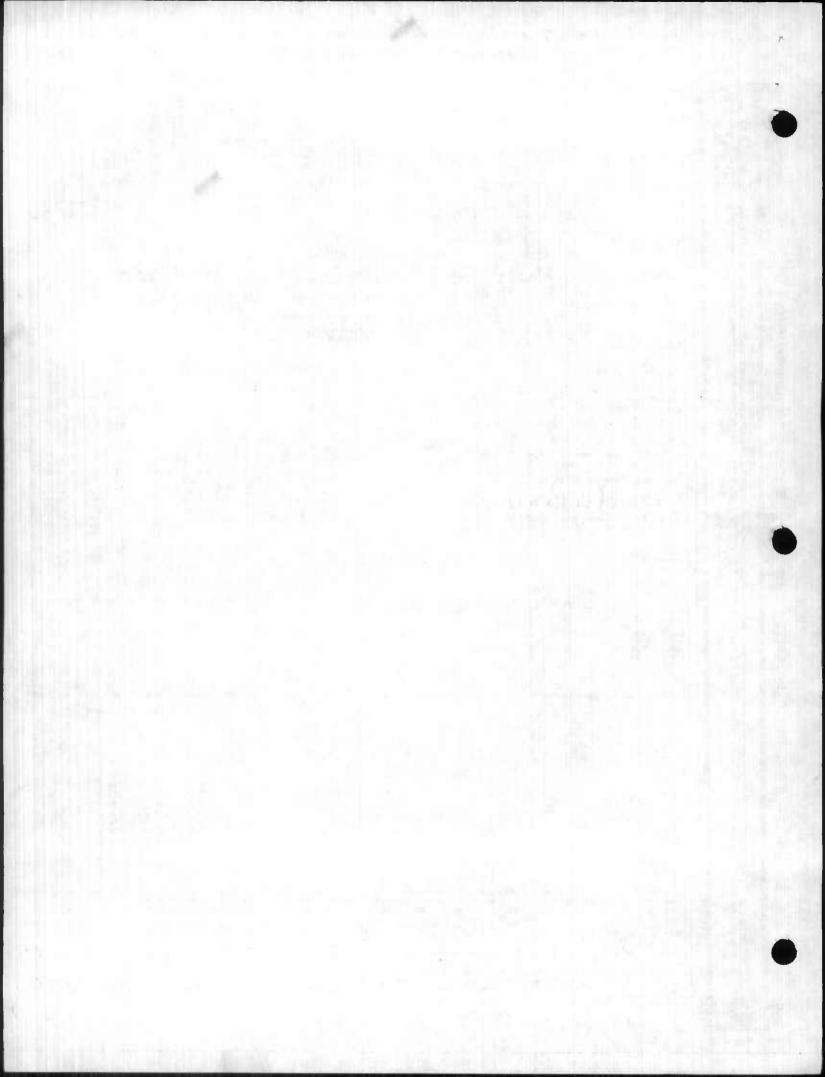
Registrar



State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate	of D	Death		F	Reg. No.	0 2	20160		
	1. Decedent's Name (First, Middle, Las)						te of Dea	th Day	Year	3. Time of Deel		
Physician /Medical	SETH JORDAN DUFFALO							AUGUST 3 20			1:35 a		
Examiner	4a Fecility Neme (If not Institution, give	street end number)			46	. City, Town	, or Location	of Death	4c. County	of Death			
	THE JOHNS HOPKINS	HOSPITAL			В	ALTIM	ORE CIT	ΓY					
Funeral Director	5. Social Security Number 6. Se none 1	X 7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Months I	Yeer Days 2	If Under 24 Hours	Min. (Mc	te of Birtl onth, Dej		Coun	iace (Stete or For itry) land		
	Usuel Residence of Decedent												
and show	Maryland Anne Aru		City, Town or Lo denton	ocation							10d. Inside City Lim 1 ☐ Yes 2 💢 I		
23s or 28s-f sho unt be notified at ral Director	10e. Street and Number 2517 Orchard Kno.	11 Way		10f. Zip C	ode 211	13			United				
ar, or harms Examinar in by Fune	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		Was Deceder If Yes, specify 1 ☐ Yes		spantc Origin , Mexican, F Specify:	n? (Specify Ye Puerto Rican,	es or No- etc.)	14. Raca - American Indian, Black, White, etc. Specify: White				
ypions, we than 'natur it, the Medical Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give life.	dent's Usual (kind of work DO NOT use	Occupat done du retired)	tion uning most o	f working	16b. Kind of Business/Industry			dustry		
the M	Elementary/Secondary (0-12)	College (1-4or 5+)	none						none				
d other went, Be C	17. Fether's Name (First, Middle, Last)					18. Mother's	Name (First,	Middle,	Maiden Sumer	ne)			
lents los es	Daniel P. Duf:	falo				De	ebbie	A1t					
of Health and Men	19e. Informent's Name/Relationship (7) Daniel P. Duffal			me as		nd Number	or Rural Route	e Numbe	r, City or Town	State, Zip	Code)		
ant of Hear nt. If Nem.	20a. Method of Disposition 1X Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph Cemetery 8/7/2000												
Departm importa any inju	21. Signeture of Funeral Service Licens		D	onald	V.	Boro	gward	t Fu	neral	Hom	e, P.A.		
	23a. Part1. Enter the disease, or comp shock, or heart tailure. List only of	licetions that caused the de ne cause on each line.								TIGIL	Approximate Interval Between Onset end Deati		
hysician /Medical xaminer	Immediate Cause (Final disease or condition resulting in death)			Т	WO DAYS								
i i		Due to	(or as a consec	quence of):									
physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	to (or as a consequence of):							6			
D #	resulting in death) Last	Due to	(or as a consec	quence of):									
d for use	Part II. Other significant conditions co	atributing to death but not re	esulting in the u	nderlying cau	ise dive	n in Part I	2	3b. Did t	obacco usa co	ontributa t	the cause of de		
	Part II. Other significant conditions co	inibuting to death but not h	esuling in the d	nderlying cau	ise give	iriir eitt.			res 2⊠ No		bebly 4 □ Unk		
2 shou							24		an autopsy med?	av co	ere autopsy findir ailable prior to mpletion of cause death?		
is certificate hadirector, page								101	es No	1[Yes 2 No		
this certificate ral director, par	25. Was case reterred to medical examiner?					26. Place o	t Death (Che	ck only o	ne)				
To dire	1 ☐ Yes 2X No	Hospital: 12 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Othe	r: 4 🗆 Nurs	ing Home 5	Resid	lenca 6 □Oti	ner (Specif	(y)		
r death. ector: After th by the funeral	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time o Injury	t 280	Injury Work 1 □ Y	at ? ′es 2 □ No		escribe t	now injury occu	rred			
12 5 E	3 Suicide 6 Could not be determined	28t. Lo	cation (S ty or Tox	Street and Num m, Stete)	ber of Rure	el Route Number,							
within 24 hours a To the Funeral D completely filled i		siclan: To the best of my kiner: On the basis of examinend manner stated.											
withir comp	29b. Signature and title of certifier	-		29c. l	License	number			29d. Date signe	d (Month,	Day, Year)		
4	30. Name and address of person who completed cause of death (Item 23s) (Type, Print) Wynne Morriso									5 August 3, 280 more ma 2128			
	O O O O O O	Moderated cause of death (It	ern 238) (Type,	>/ M	Ynr	ie Mo	rriso	of.	e c	In	2129		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature La	1	1								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death August 16, 2000 Year **Physician** Kenneth Irwin Davey, Jr. 7:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9262 Cherry Lane #41 Prince George's Laurel If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 8. Date of Birth (Month, Dey, May 23, 7. Age (In vrs. last birthday) 9. Birthplace (Stata or Foreign **Funerai** 18 M 2□ F Months Days Hours Min. 218-56-9352 49 May 1951 Washington, D.C Director Usual Residance of Decedent 10a State 10b. County 10c. City. Town or Location show 10d. Inside City Limits must be notified at MD Director Prince George's Laurel 1 ☐ Yes 2X No 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 9262 Cherry Lane #41 "natural", or items 23a 20708 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elamentary/Secondary (0-12) Pest Control Exterminator permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofthe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Meiden Surname) Be Kenneth Davey, Sr. Wanda McDaniel 19a. Informent's Name/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Karen Kohnen/Daughter 8397 C Montgomery Run Road, Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/00 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Donaldson Funeral Home, P.A. MO1103 313 Talbott Avenue, Laurel, MD 20707 For the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, heart failura. List only one cause on each line. pproximate Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Metastatic Prostate Cancer 1 1/2 yearsExaminer Due to (or as e consequance of) Examiner certificate be axecuted and Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undarlying Cause (Disaase or Injury Due to (or as a consequence of) physician ar s the burial-t Box 68760. Physician/Medical thet initiated evants resulting in deeth) Lest Due to (or as a consequence of): ettanding p P.O. ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. by 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy hes page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Be 25. Was case referred to madical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) funerai 27. Manner of Daath 28d. Describe how injury occurred Certification: After 1 Injury at Work? or Attending 5 Panding Investigation daath. 1 Yes 2 No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 Homicida hin 24 hours aftar the Funeral Dire mplataly filled in b Hospital To cartifying Phyaician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es statad. 29a. Certifiai Medical (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. within 2 To the i 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0031586 30. Nama and addres person who completed ceuse of deeth (Item 23a) (Type, Print)

University of Maryland; Bathmore MD

Registrar

State

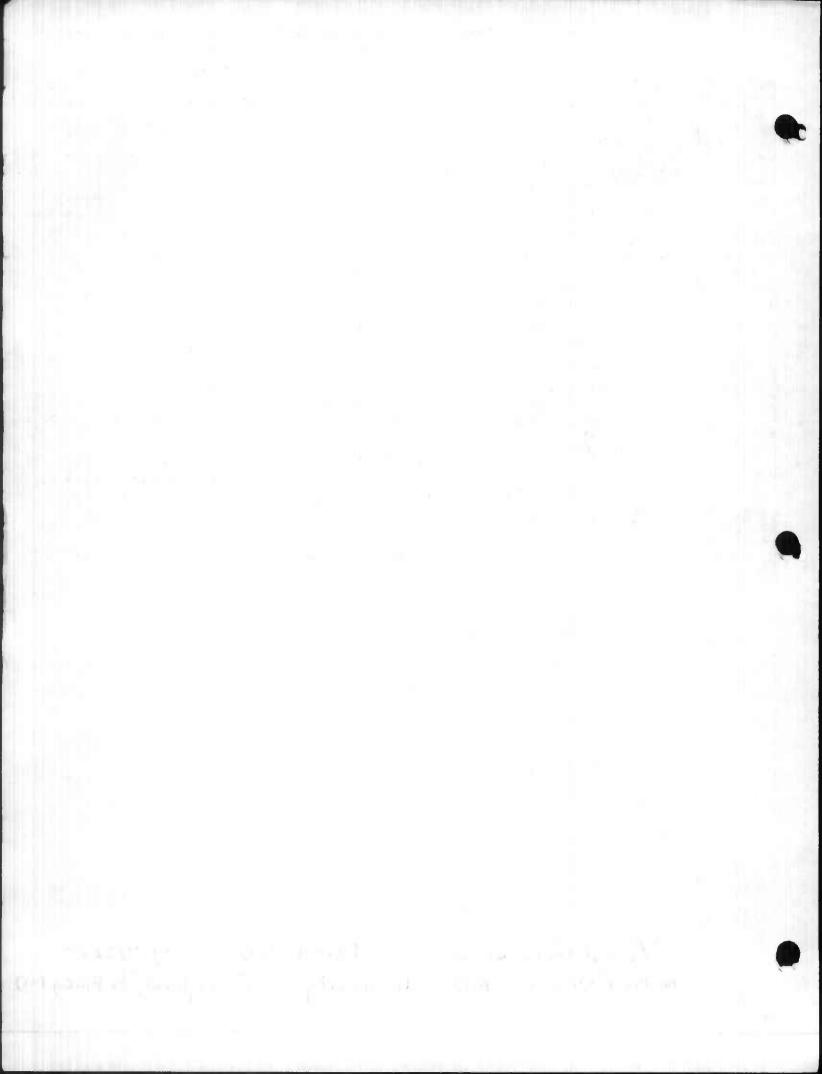
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31. Date filed (Month, Day, Year)

AUG 1 8 2000

DAWSON MD.

32. Registrer's Signatura



State of Maryland / Department of Health and Mental Hygiene

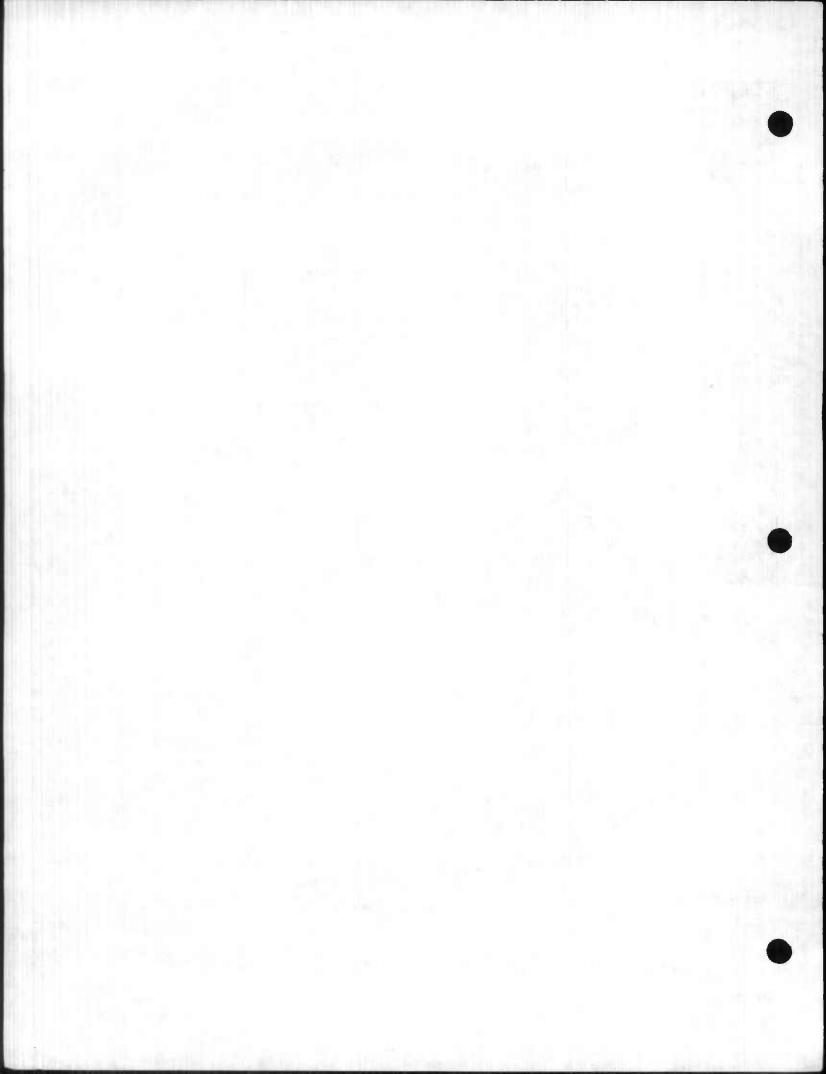
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NATIONAL LUTHERAN HOME FUND TOTAL 199-12-9093 6.5ax	No.	20120										
**A Facility Name of Incident Part Indiana State As Facility Name of Incident Part Indiana Sta	Dey _ Yaar	3. Tima of Death										
Social Security Number 199-12-9093 10 M 20F	4c. County of Dea	9:20 Al										
Usual Residence of Decedent 10c. City, Town or Location 10c. City Town or Lo	MONTGOM 9. Bir	IERY inthplace (Stata or Fore										
100. Stelle 100. County	APR • 21, 1915 PENNSYLVA											
12 West Decedent Ever in U.S. Amad Force; 13 West Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxindar, Puerfo Rican, sto.)		10d. Inside City Lim 1 X Yas 2 ☐ 8										
12. Maried Status 12. Maried Status 12. Maried Status 12. Maried Status 13. Maried Status 13. Maried Status 13. Maried Status 13. Maried Status 14.	Citizen of What C	ountry?										
Elementary/Secondery (0-12) College (1-4or 5+) SCHOOL TEACHER	14. Raca - Ami Bleck, Whi Specify: WH	ite, etc.										
1. Feitres Neme (First, Middle, Masters 1. Feitres Neme (First, Midd	16b. Kind of Business/industry											
The first and the first, Middle, March Mark WILSON JAMES McCREADY 19a. Informant's NemerReletionship (Type, Print) 19a. Informant's NemerReletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City, 19537 VEIRS DRIVE #3 ROCKVI) 20b. Method of Disposition 10m Burial 2 Coremation 3 Removal from State 10m Burial 2 Signature of Funerel Saffaça Ucansee 12m Burial 2 Signature of Funerel Saffaça Ucansee	EDUCAT	CATION										
AR - EDWIN EMERY - HUSBAND 9537 VEIRS DRIVE #3 ROCKVI 20a. Method of Disposition 1 M Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Charles (Spacify) 24 Donation 5 Charles (Spacify) 24 Donation 5 Charles (Spacify) 25 Nama and Address of Facility HYSONG CO - INC - 6510 - 16th STREET, NW, Shock, or hard tailure. List any one datume on each line. Sequentially list conditions, and the interied avants 15 15 15 15 15 15 15 1	ten Sumame)											
Section Sect	ty or Town, State, ILLE, MD	Zip Code) 20850										
23e. Pert1. Enter the disaesa, or portplications are caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, enter the disaesa, or portplications are caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, enter the disaesa or condition resulting in death) Due to (or as a consequence of):	lery, cremetory or other place)											
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24e. Wes an autoperformed? 1	23b. Did tobacco use contribute to the ca											
25. Wes case rafarred b medical axisminar? Hospitel: I Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 27. Menner of Deeth 28a. Deta of Injury 28b. Time of Injury 28d. Injury et Work? 1 Ves 2 No Nursing Home 5 Residence 28d. Describe how Injury 28d. D		Probably 4 Unknown										
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S Suiside 6 Could not be		ecify)										
286. Pieca of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 286. Location (Street as City or Town, State	and Number or R tata)	Rurel Route Number,										
29a. Certifiar (Check only Check on Check only Check on Check only Check on	end place, and du	is stated. le to the cause(s)										
end manner steted. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. Licansa number 29d. Da	Data signed (Mon	1th, Day, Yaar) 9,2000										
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) DR. CHARLES W. KARESIJ 9701-VEIRS DR. A	LOCKVI	LLE, MD										

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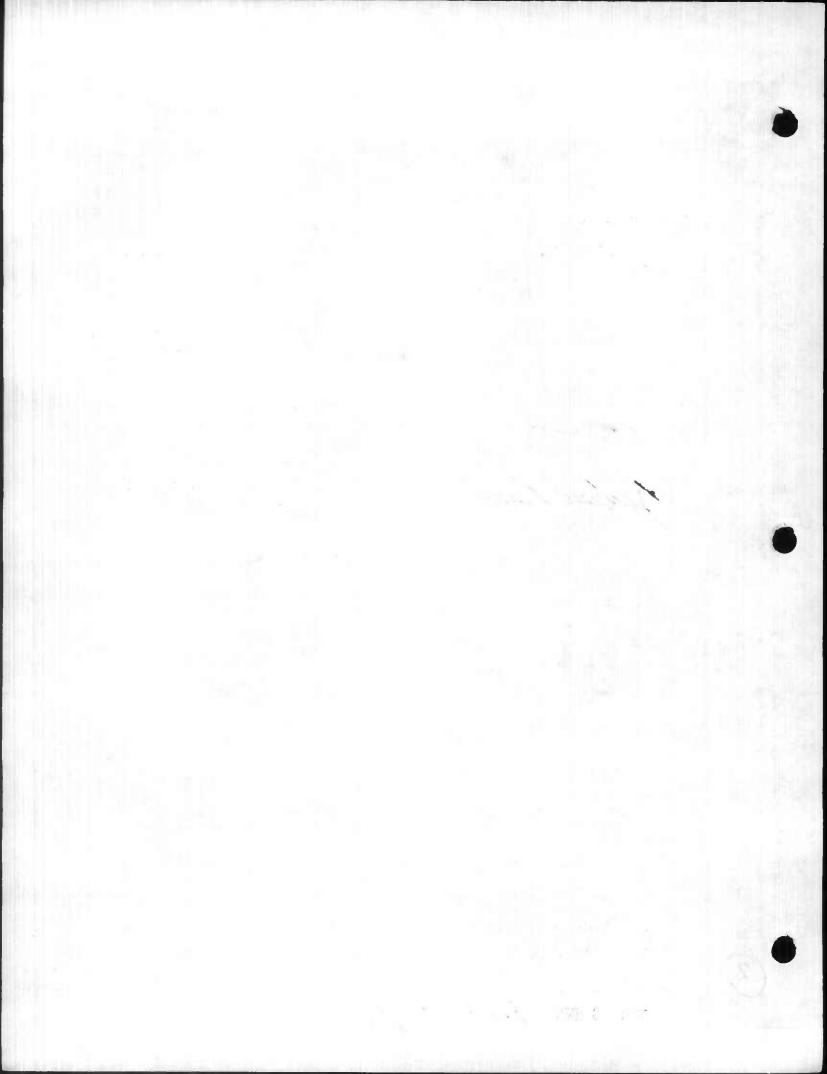
State of Maryland / Department of Health and Mental Hygiene 00 26726

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/Med								4h Chu Tourn o	August			8:10PM	1	
Exam	iner	4a Facility Name (If not institution,	AND VENEZUE		3.11				r Location of Deat					
		263 Congressional Lane Apt. 604 Rockville 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.								Monte				
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Directo	'	577-28-3015 TEM 20F 77 Yrs. July 6, 1923 Wa Usual Residence of Decedent											D. 0	
A Maria		10a. State 10b. County 10c. City, Town or Location											Limits	
Many Head	tor	Maryland Montgo	merv	Ro	ckvill	e						1 Yes 2	□ No	
128	Directo	10e. Street and Number	J			1	ip Coda			10g. Citizen of What Country?				
after death with the Maryla or Herre 23e or 28e-f shor miner must be notified at		263 Congressiona	A 724	United	Stat	00								
deat deat	Funeral	11. Marital Status	12. Was Decede	ent Evar in U		Was Dec		0852 Iispanic Origin? (Specify Yes or No orto Rican, atc.)		e - Amaric	an Indian,		
or its		1 Nevar Married 2 Marrie	Armed Force	No.			2 No	Specify:	nto Filcan, atc.)		k, White,	etc.		
Eng.	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 U Yes	2 (£3 NO	Speciny:		Specify	Whi	ite		
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un un un	nple.	Elementary/Secondary (0-12)	College (1-4	or 5+)				during most of w			E.			
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Wants Hy whats Hy what other tic event.	Be c	17. Father's Name (First, Middle, L							ame (First, Middle	, Maiden Sumem	ie)			
should nd Men marks umarks	00	Michael Lars Eig						Helen W						
2 sty		19a. Informant's Name/Relationsh			111111111111111111111111111111111111111				Rurel Route Numb					
		Helen B. Eidsnes	ss/Wife	lant s				onal Lar	ne Apt. 60				852	
permit. Pages 1 a Appartment of Hea mportant: If Item:		20a. Method of Disposition 1 D Burial 2 A Cramation	3 □Ramoval from Sta		Placa of Dispo cematery, crer	netory or	other ple	ce)	Aug. 2	20c. Location -	City or To	own, State		
Part Hard		4 ☐ Donation 5 ☐ Other (Sp		m, Inc.	2000			laryland						
ppart in in	4	21. Signature of Fundal Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue												
20221	9	XITE		MO1126	B	ethe	sda-u sda,	Marylan	d 20814-	3501 WI	scons	sin Aven	lue,	
		23a. Part1. Entar tha disease, or a shock, or heart tailure. List of	complications that cau	sad the daat	th. Do not ent	ar tha mo	ode of dyli	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between	en	
Physician	n											Onset and Dea	ath	
/Medica	_	Immediate Cause (Finel disease or condition	Core	onary	Arterv	Dis	ease					Years		
Examine		disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence ot):												
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ires that the death or signed by the attended by the attended for un	Physician	Part II. Other significant condition	e contributing to deat	h but not res	sulting in the u	nderlying	cause gi	van in Part I.		tobacco use co				
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Physician: The I this certificate he	Be	25. Was case reterred to medical examiner?	Hospital:				OH	nar:	eath (Check only		46			
हें हैं है	1. 70	1 Yes 2 No 27, Menner of Death	1 Inp		28b. Time o		JUA	4 LI Nursing	Home 5 N Res	how injury occur		ואי		
After funer	For	1 Netural 5 Pending	(Month,	Dey Year)	Injury	М	28c. Inju Wo	rk? Yes 2□No						
Attending r death. ector: Afte by the fune	Certification:	3 Suicide 6 Could n	ot be 290 Place of	Injury - At h	ome, tarm, str				28f. Location	(Straat and Numb	per or Rur	al Route Numbe	er.	
or Attending after death. Director: Atte	F	4 ☐ Homicide determi		wn, Stete)										
ours ours filled		29a. Certifier 1 Certifying	Physician: To the be	est of my kno	wiedge, death	n occurre	d el the ti	me, date and pla	ce, and due to the	ceuse(s) and me	enner as s	stated.		
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai		xaminer: On the basi	s of examina										
o the	Z	one) and manner stated. 29b. Signature and little of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year)												
10)	5567 August										2000		
10		30. Name and address of person who completed cause of deeth (Item 23a) (Typa, Print)												
		Bernard R. Farzin, M.D. 7525 Greenway Drive, T3, Greenbelt, Maryland 20770												
9	tate	31. Date tiled (Month, Dey, Year)	-	istrer's Signo						J			0	
_ ;		ALICARIA	A		4	1	- 1	A						



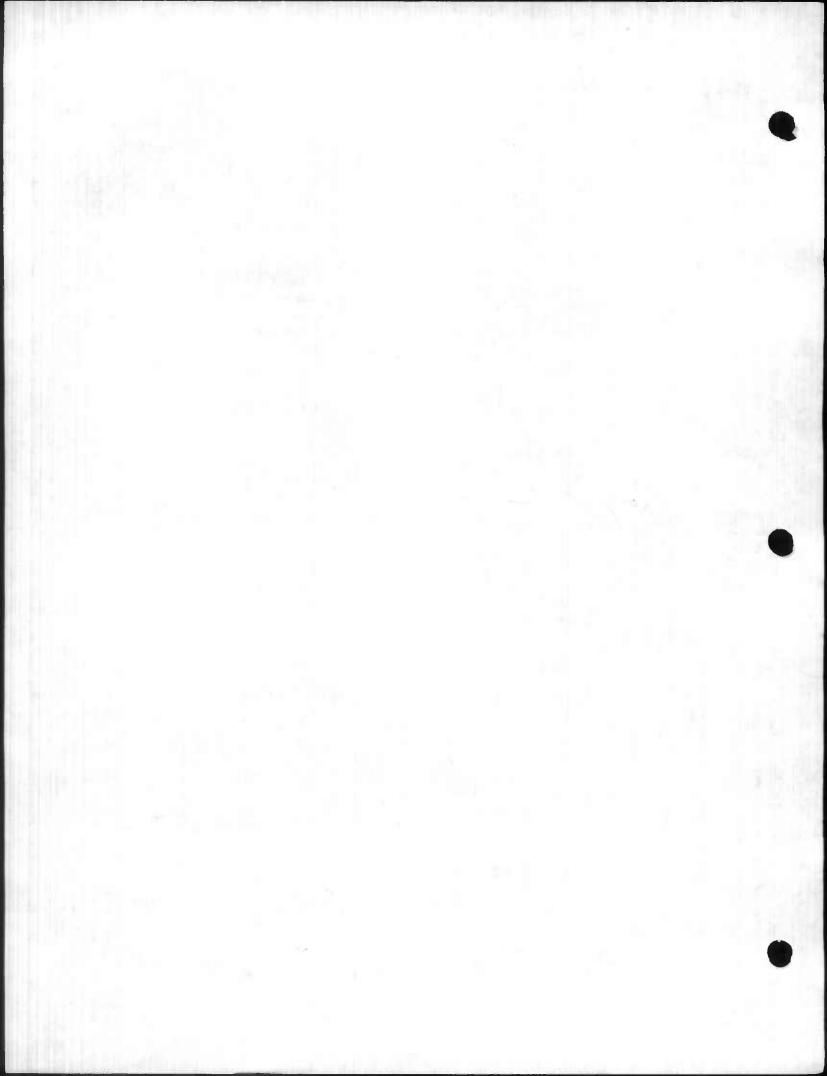
State of Maryland / Department of Health and Mental Hygiene 10 26727

				Certifi	icate of	Death	,	Reg. No.	1 6	0121
		1. Decedent's Name (First, Middle,	ast)				2. Date of Dec	eth	V	3. Time of Death
1	Physician /Medical	Marie	Fi	iorito			Month A u g	10 ^{Dey} 2000	Year)	6:10 AM
	Examiner	4a Facility Name (If not institution, g				4b. City, Town, or	Location of Death	4c. County of	d Deeth	
1		Avery Garden	s Assistant			Lanham		Princ	e Ge	eorges
	Funeral Director	5. Social Security Number 073-14-4226 Usual Residence of Decedent	Sex 1□M 2\(\tilde{\text{X}}\) 7. Age (In) 9 4		Under 1 Yeer onths Deys	If Under 24 Hrs Hours Min.	8. Dete of Birtl (Month, De) May 9	1906	9. Birthpla Countr Ital	ce (State or Foreign y) L Y
	pue te	10e. State 10b. County	10c.	City, Town or Location	on		1-5	1777	100	d. Inside City Limits
	with the Maryland a or 28a-f show Les notified at	Maryland Prince	Georges	Green be						1 🖫 Yes 2 🗆 No
	ms 23a or 2 result be n	9885 Greenbelt	Rd.			770		U.S.A	١.	
21215-0020	urs after alf, or he by Fu	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of hes, specify Cub	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	Bleck	- America , White, et White	c.
5-0	natural.	15. Decedent's (Specify only highest)		16a. Decedent' (Give kind	of work done	during most of wo	rking	16b. Kind of Bus	iness/Indu	stry
121	ed within 72 ho yglene. We then natural, to the Madeel Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		VOT use retire	d)		Lord 8	Tov1	
	should be filed withing Mantel Hyglena. marked other than marked avent, the Mantel To Be Comp	17. Father's Name (First, Middle, La	U C	Sales	Clerk	18 Mother's Ner	me (First, Middle,	Lord &		or
Maryland	Mentel H Mentel H arked out artic aver						no (i iist, iiiissio,	Welder, Dameine	,	
2	and Men and Men aumatic	Guiseppe Mancu		19h Meiling A	ddraes (Strae)	Unk.	ural Route Numbe	or City or Town 5	Stele Zin (Codel
S	0 - 2 -	Ralph Fiorito				ace Sil				
e,	parmit. Pages 1 end Department of Health Important: If item 27 eny injury or other to page.	20a. Method of Disposition		b. Place of Dispositio	n (Neme of		Dete	20c. Location - C	City or Tow	n, Stete
E	2527	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		ate Of Hea			8/15/m	Hawthorn	No No	ou Vork
aitimore	Department Parish Important: eny injury poce.	21. Signature of Faneral Segrice Lic		22. Na	me end Addre	ss of Facility				
Ö	Depa Impo eny ii	1 Alpho	Denl-	Va 54	ander M	lay Wayne	Colonia	1 Funera	1 Hor	ne
-		23a. Pen Enter the disease, or co	mplications that caused the d	eath. Do not enter th	e mode of dyi	er Rd. W	c or respiretory er	w Jersey rest,	- 1	Approximete
	Physician	or heart tailure. List or	y one cause on eech line.							ntervel Between Onset and Deeth
7	/Medical	Immediate Cause (Final disease or condition	t on verse		~~~	Fh				
	Examiner	resulting in death)	e. Conges	o (or as a consequen	ce of):	FACUI			1	
	axecuted in and hal-transit		CHRON	C REN	h 1	NS UTTER	CIENCE			
	and trans	Sequentially list conditions,	D	o (or es a consequen					1	
90	be axed iclan and burial-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ALPER	TENSIA	4				1	
68760,	# # # B	that initiated events resulting in death) Last		o (or as a consequence						
	\$ P. S		d						i	
Box	e attandir of for use siclan/A								- 1	
o	y the d	Part II. Other significant conditions	contributing to death but not	resulting in the under	tying cause gi	ven in Part I.				the cause of death?
9	ed by deta						10'	Yes 2∐No	3 Probe	ibly 4 Miknown
Records,	een signed hould be del	The Part of the Pa					24a. Wes	en eutopsy		e autopsy findings
00	> 0 0				2		perfo	rmed?	com	lable prior to pletion of cause eath?
Re	The lew require sate has been single 2 should Completed						101	res 2 No		Yes 2 No
Vitai	cartificate has rector, page 2	25. Was case referred to medical				26 Plane of De	eth (Check only o		- 10	165 215110
>	Physicien: this certific ral director,	axaminer?	Hospitel:	ER/Outpatient 3	DOA O	200:	tome 5 Resid		r (Specify)	
of		27. Manner of Death	28a. Date of Injury (Month, Day Year		28c. Inju Wo		Υ	now injury occurre		
Division	tal or Attending P is after death. el Director: After t led in by the funen Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	on			Yes 2 No				
<u> </u>	or Attendi after death. Director: A d in by the f	3 Suicide 6 Could not determine			factory, office		28f. Location (5 City or Tox	Street end Numbe vn, Stete)	or Aural	Route Number,
	Central of									
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Physician: To the best of my laminer: On the basis of exam and manner steted.	knowledge, death occ linetion and/or investi	curred at the ti gation, in my o	me, date and place opinion, death occu	e, end due to the curred et the time,	cause(s) and mer date end plece, a	nar as sta nd due to i	ited. tha ceuse(s)
	To the within To the comple	29b. Signature and title of dertified			29c. Licens	se number		29d. Date signed	(Month, D	ay, Year)
	6	- Hill	L HB			5555	9	August	10	2000
	(2)	30. Name end address of person wh	o completed cause of death (4	BEEN BOT
		31. Date filed (Month, Day, Year)	22. Registrar's Si		4722	EHWAY &	STERS.	DE # 31	6, 1	orras am
	State Registrar	AUG 1 0 2000	Serva	B. L.	aus.	,				



State of Maryland / Department of Health and Mental Hygiene 00 26728

					C	entitica	ate or	Death			Reg. No	٥.			
	ysician	Margaret Ann Fenderson August 5 2000											Year	3. Time o	
	Medical aminer	4a Facility Name (If not institution, g					T	4b. City, Tox	wn, or Lo	ocation of Dea	-		of Death	2.50	111
EX	ammer	Potomac Valley						Rocky	vi11	e)	Mont	ntgomery		
Fun	oral		Sex	7. Age (In yrs	. last birthd		der 1 Yaar	If Undar	24 Hrs.	_					or Foraign
Dire	_	5. Social Security Number 578-22-4058 6. Sex 1 Months Days Hours Min. (Month, Day, Year) Feb. 26, 1922 W. Usual Rasidence of Decedent										Washi	ngton	, D.C	
D .		10a. State 10b. County		10c. C	ity, Town o	r Location							1	Od. Insida C	City Limits
with the Manyland s or 28a-f show	ctor	Maryland Montg	omery		Che	vy Ch	ase							1 ♣ Yas	2 No
20 atter death with the Maryla or Items 23s or 28s-f shor	it be notified	10e. Street and Number 7015 Meadow La	ne			10f.	Zip Coda 20	815				g. Citizan of What Country? Jnited States			
Ta de	Sper must	11. Marital Status	12. Was De	cedant Ever in t	nt Ever in U,S. 13. Was Decedent of Hispanic Origin?					ecify Yes or N	0-	e - Amaric			
5-0020 72 hours atter natural, or its	by Fur	1 ☑ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 2 Yas If Yas, G Yaar or	2 No WW			pecity Cub		, Puarto	Pican, etc.)	Specify	ck, White, ^{y:} Whi	White		
2 hou		15. Decedent's	Education		16a. De	ecedant's U	sual Occu	sual Occupation work dona during most of working I usa retired)					usiness/Inc	dustry	
within 7 ene. Then 'n	Completed	(Specify only highast g Elemantary/Secondary (0-12)		(1-4or 5+)								aw			
/land 2	Be Co	17. Father's Nama (First, Middla, Las Albert A. Fende	-							e (First, Middle e Wing		n Suman	na)		
and 2 should be seth and M	r fraumati	19a. Informant's Name/Ralationship (Type, Print) Barbara F. Rommel/Sister 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, 9040 Rouen Lane, Potomac, Maryland 2									, State, Zip 20854				
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at begamment of Health and Markal Hygiene. mportant: If them 27 is marked other than "natural", or	-116	20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematery, crematory or other place) Montgomery Crematorium, Inc. 20c. Location - Ci Aug. 7, Bethesda.												d	
Baltin permit. P Departmi	any injur	21. Signature of Funeral Service No.	COLUMN TO THE REAL PROPERTY.			Rober 7557	and Addra	Pumph	rey	Funera			Sethes Cha	sda-Ch	evy
		23a. Part1. Entar the disaasa, or co shock, or haart failura. List on	mplications that	M001		Bethe	sda,	Maryl	and	20814		1	1	Approxima Interval Be	ita
Physic			,											Onset and	
/Med Exami		Immediate Cause (Final disease or condition rasulting in death) Carcinoma Metastatic to Brain Due to (or as a consequence of):													
D	ner ner		Sm	all Cel				the L	ung					1 yea	ır
68760, tificate be executed g physician and	Examiner	Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of):												-	
)X 68760, certificata be execut ding physician and	sa as tha bu														
Be atte	for u	d													
0. th	detached for u	Part II. Other significant conditions	contributing to	death but not re	sulting in th	na undarlyin	g cause g				_	cco use contribute to the cause of death?			
dS, P ires that signed b	p A														
aw requ	. page 2 should									24a. Wa per	s an auto formed?	opsy	av	ere autopsy vailabla prior emplation of death?	to
He de	Page Com									10	Yas :	2 🖾 No	1 (□Yes 2□	□ No
of Vital Physician: The Physician: The Physician: The Physician The Phys	rector.	25. Was casa referred to medical axaminar?						26. Place	of Deal	h (Chack only	one)				
y y sic	0 2	1 ☐ Yes 2 No	Hospital: 1	Inpatiant 2	□ ER/Outpa	atient 3	DOA O	thar: 42 Nu	rsing Ho	me 5 Ra	sidance	6 □Otl	har (Specil	<i>(y)</i>	
E 2 2	unera On:	27. Manner of Death 1 Natural 5 □ Panding 2 □ Accident Invastigat		a of Injury onth, Day Year)	28b. Tim Inju		28c. Inju	uryat ork?]Yes 2□	No	28d. Dascribe	how Inj	ury occu	rred		
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	ed in by the funera Certification:	3 Suicide 6 Could not determine	d 286. Plat	ce of Injury - At I ding, atc. (Spec	homa, farm	, straat, fac	tory, office			28f. Location City or To	(Street a	and Num ta)	ber or Run	al Routa Nui	mber,
Me Hospitum 24 hours	completely filled Medical Ce	29a. Certifier (Check only one) 1 Certifying F	miner: On tha												(s)
To the	W.	29b. Signatura and titla of certifiar		0			29c. Lican	sa number			29d. D	ate sign	ed (Month,	Day, Year)	The T
7		() () () () () () () () () ()									7, 2	000			
		30. Name and address of person wh					11 1 1	D7 1	~	. 1				1 0	*
	0	Burt Ira Feldman, M.D. 3305 N. Leisure World Blvd., Silver Spring, Maryland 2090 31. Data filed (Month, Day, Year) 32. Registrar's Signature										0906			
D-	State	31. Data filed (Month, Day, Year)		Hegistrar's Sign	19	1	200 1								



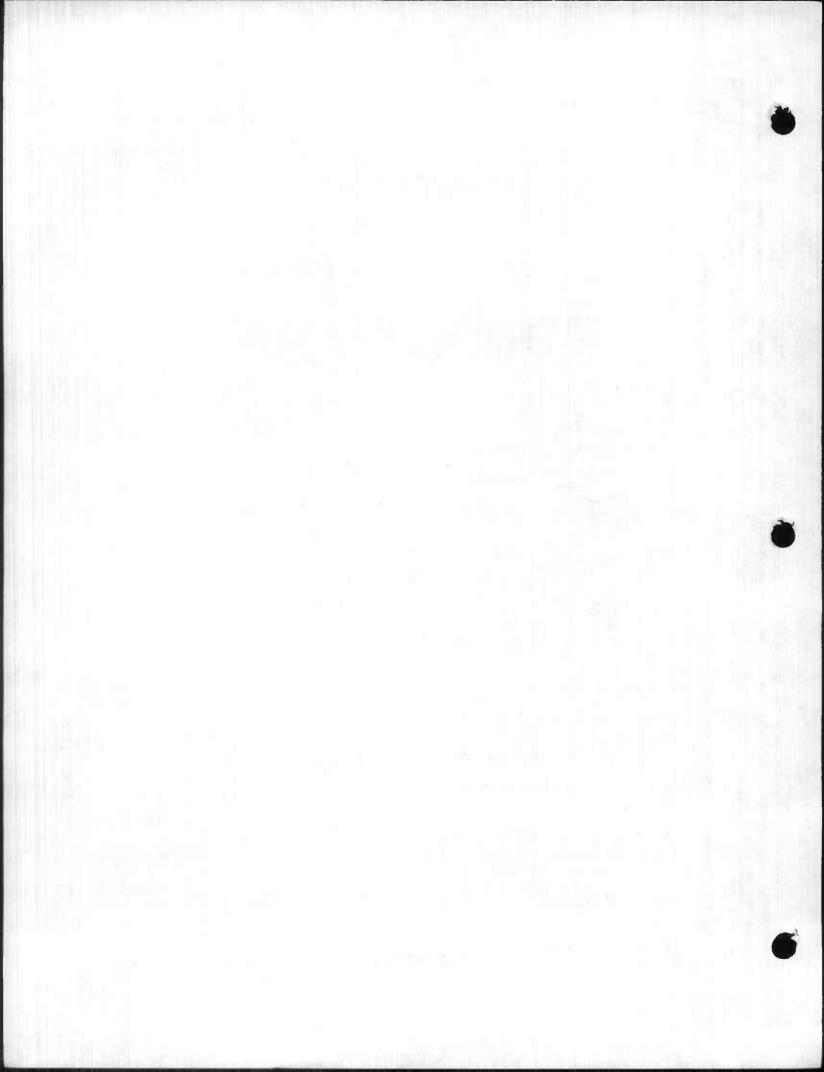
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	f Death		Reg. No.	10	20125				
sician	1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dey Ye											
edical	SADELLE FISHMAN				AUGUST	6 20		1:00PM				
miner	4e Facility Neme (If not institution, give street and number 8204 LOCHINVER LANE)		4b. City, Town, or L	ocation of Death		c. County of Deeth					
-		an Ha was to at his	thday) If Under 1 Yes	POTOMAC If Under 24 Hrs.	Dota -4 Bi-		NTGOM					
	109-22-8124 1□ M 215 F	ge (In yrs. last bir	Yrs. Months Day:		8. Dete of Bir (Month, Da FEB 1	y, Year)	(ear) 9. Birthplace (State or For Country) MASSACHUSETT					
	Usual Residence of Decedent 10e. Stete 10b. County	10c. City, Town	n or Location				10d. Inside City Lin					
ŏ	MD MONTGOMERY	PO	TOMAC					Yes 2 1				
Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	. Citizen of What Country?					
	8204 LOCHINVER LANE		208	5/			S.A.					
Funeral	11. Merital Status 12. Was Deceden	Ever In U,S.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No		ce - Americ	cen Indien,				
by	Armed Forces 1 Never Merried 2 Merried 1 Yes 2 If Yes, Give Yeer or Detes:		1 Yes 2 No		Hican, etc.)	Specia	ck, White, fy:	HITE				
rted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occi (Give kind of work don- life. DO NOT use retir	upation	ina	16b. Kind of E	lusinass/în	dustry				
Completed	Elamentery/Secondery (0-12) College (1-4or	5+)	life. DO NOT use retir	red)	9							
S	4	T	EACHER					CHOOL				
8	17. Fether's Name (First, Middle, Last)			18. Mother's Nam			ne)					
10	NATHAN WOOLF				BLEVITSI							
	19e. Informent's Name/Raletionship (Type, Print) WILLIAM L. FISHMAN/SON		Mailing Address (Stree					Code)				
	20e. Method of Disposition		04 LOCHINVE Disposition (Name of	LR LANE, PO	Dete Dete			num State				
	1型 Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)	cemeter	y, crematory or other pl	P	Dete 20c. Location - City or Town, Ste			own, Stete				
4 4 8	21. Signeture of Funerel Service Licensee	_	22. Name end Add		VEVODE	T GILLDI						
	1			-GOLDBERG								
	208. 23a. Pert1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.											
	Immediate Cauce /Finel											
	Immediate Cause (Finel disease or condition resulting in death) RESPIRATORY COMPROMISE											
-			consequence of):	OF TIME				1 1 MONTHIA				
edical Examiner	b		OCARCINOMA	OF LUNG			-	11MONTHS				
Exal	Sequentielly list conditions, if any, leading to immediate	Due to (or as a c	consequence of):									
cal	Cause (Disease or injury that initiated events	equentielly list conditions, any, leading to immediate ausa. Enter Underlying ause (Disease or injury c										
led	thet initiated events resulting in daeth) Last Dua to (or as a consequence of):											
M/W												
Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributions.											
Ph.	1 Yee 2 No 3											
ò												
Completed by					24a. Was perfo	an autopsy med?	8\	era autopsy finding vailable prior to				
pie					100		of	ompletion of ceuse death?				
5					10	Yes 2 No	1	☐ Yes 2 No				
90	25. Was casa referred to medicat axaminar?			26. Place of Deat	h (Check only o	one)						
0	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpati		tpatient 3LI DOA	Ather: 4 Nursing Ho				(y)				
Certification:	27. Mennar of Death 1 A Natural 5 Panding 2 Accident Investigation	ary 28b. T	njury W	ury at ork? Yes 2 No	28d. Describe	how injury occu	rred					
erume	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not ba datarmined 28e. Plece of In building, a	28f. Location (City or To	Street and Num wn, State)	ber or Run	al Route Number,							
edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of the be	f examination and	, death occurred at the Vor investigation, in my	time, date and place, opinion, death occur	end due to tha red at the time,	cause(s) and m date and place	enner es a , end dua t	stated. o the cause(s)				
Me	29b. Signeture end title of certifier		29c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)				
	> / m /	00	Das	006		08-08-	-2000					
	30. Name and eddress of parson who completed cause of	seeth /Hom 2201	Type Print)	770		00-00	2000					
	30. Name and eddress of person who completed cause of death (Nem 23a) (Type, Print) LINDA M. BURRELL MD 2730 UNIVERSITY BLVD. #400 SILVER SPRING, MD 20902											
ate		rar's Signature	21-1 I LINDIII	22721 11701	O DILIY.		-,					
ate	BILO 4 A											

DHMH 16 Rev 6/95

Registrar

G. Sparks



State of Maryland / Department of Health and Mental Hygiene

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			Certificate of	Death	Re	z. No.	20100
	1. Decedent's Name (First, Middle, Last)	variety of the	Per Tooling		2. Date of Death Month		3. Time of Death
Physician /Medical	Elenora T. Green				AUGUST	8 200	
Examiner	48 Fecility Neme (If not institution, give stree Doctors Hospital	et end number)		4b. City, Town, or L Lanham	ocation of Deeth	4c. County of I	
Funeral Director	5. Social Security Number 6. Sex 575−38−7543	7. Age (In yrs. lest	birthdey) If Under 1 Yeer Months Days		8. Date of Birth (Month, Day, Jan. 26	(ear) 9.	Birthplace (State or Foreig Country) Maryland
8 *	Usual Residence of Decedent	100 City T	our or Leasting				and levide City Limit
Maryla el shor filed al	Maryland Prince Ge		own or Location College	Park			10d. Inside City Limit
with the Mary a or 28a-1 sh be notified. Director	10e. Street and Number 4740 Lakeland Ro	- 4	10f. Zip Code	20740	10	g. Citizen of Wha	
E 21 H			Too we a		74 34 34		ed States
st, or here: Example: my by Funer	1 Never Married 2 Married	Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2≦ No If Yes, Give Yeer or Detes:	13. Was Decedent of If Yes, specify Cul		Rican, etc.)		American Indian, White, etc. Black
72 ho hattur Scal	15. Decedent's Education (Specify only highest grade co	on 10	6a. Decedent's Usual Occu (Give kind of work done	pation	ing 1	6b. Kind of Busin	ess/Industry
ud within 72 ho yglane. we than "natural, the Medical. Completed		College (1-4or 5+)	life. DO NOT use retin	ed)		Co	vernment
	17. Father's Name (First, Middle, Last)		Secre		e (First, Middle, M		veriment
d 2 should be filled within 72 hours at the and Merital Phygiana. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	Ashby Tolson,	Sr.		10. Mother's Ivani	Alberta		
aith and 27 is m or traum	19a. Informant's Name/Relationship (Type, Ashby Tolson - Bro	Print) 1 ther	9b. Mailing Address (Stree 1356 Newton				ote, <i>Zip Code)</i>
Pages 1 nent of He ant: If flem ary or oth	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆 Remide 4 🗆 Donation 5 🗆 Other (Specify)		of Disposition (Neme of etery, cremetory or other pland Nationa		Date 2 /14/2000	Oc. Location - Cit Laur	y or Town, State
Depart Importu eny inj ance	21. Signature of Funeral Service Licensee	and TIT	22. Name and Addr 4001 Benn	ess of Facility Sing Rd.,	tewart Fu N.E. Wash		
	23a. Part. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the comp	ons that caused the deeth. D					Approximate Intervat Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	CORONALY Due tolor as CHERONIC	a consequence of): Mesholish	Disees	ie.		
certificate be executed ding physician and use as the bural-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Lasf						
atter for i	d				Oth Didash		
that the de ed by the detached	Part II. Other significant conditions contrib	uting to death but not resulting	g in the underlying cause g	ven in Part t.	1 Ys		Drobably 4 Unknown
s been sign 2 should be pleted by					24a. Was an perform		24b. Were eutopsy finding eveilable prior fo completion of cause of death?
The law ate has page 2					1 ☐ Yes	2 1 No	1 Yes 2 No
ysician: The scentificate director, pag	25. Was cese referred to medicet examiner?			26. Place of Dea	th (Check only one)	
2 00	1 Yes 2 No Hosp	nital: 1- Inpatient 2 ER/	Outpatient 3 DOA	ther: 4 Nursing H	ome 5 Resider	nce 6 Other	(Specify)
Attending Ph r death. ector: After thi by the funeral lflcation: 1	27. Manner of Death 1 Maturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of Injury M 1	28d. Describe how injury occurred			
Part in Direct	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or To					or Rural Route Number,
he Hospital in 24 hours he Funeral pletaly filled edical Co		n: To the best of my knowled On the basis of examination and manner stated.					
within 24 To the Fu complete	29b. Signature and title of certifier	1/11/	29c. Licer	se number	29	d. Date signed (/	Month, Day, Year)
2	1/ mu &	At my		14/20	60	08/09	00/5
(4)	30. Name and address of person who complete NORMAN Smile	veted ceuse of deeth (Item 23	a) (Type, Print) My + ohelly	le RD	#104,	Bouse	NO 207/6
State Registrar	31. Date fited (Month, Dey, Year) ALIG 1 2000	32 Registrer's Signeture	6 1.		•		

State of Maryland / Department of Health and Mental Hygiene

					Certificate	of Death		Reg. No.	0 26	131
Observation .		Decedent's Nama (First, Middle, La	est)				2. Data of De	eath Day	3. Tin	ne of Death
Physician /Medical	Purnell Delaney Green						August	8, 2000	8:3	30 p.m
Examiner	4.0	Facility Nama (If not institution, gir	ve street and number)			4b. City, Town, or	Location of Deet	h 4c. County	of Death	
		Washington Adve				Takoma 1	Park	Montg	omery	
Funeral Director		220-98-4198	3.5	a (In yrs. last	birthday) If Under 1 Yrs. Months D	Yaer If Under 24 Hrs Deys Hours Min	8. Data of Bi (Month, Di Septemb	er 24,19	9 Birthplaca (St Country) 966 Washi	ata or Foraig
faryland fahow ed.st	108	a. State 10b. County M. D Prince	Georges	10c. City, T Suit!	own or Location					de City Limit
th with the Marys 23e or 28e-f sho sat be notified at al Director	104	a. Street and Number 3312 Curtis Dri	ve #203	26	10f. Zip Co 2074			10g. Citizen of W United S		Amer
ar, or flams Examiner in by Funer	á	Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yas 2 N If Yas, Giva Yaar or Datas:		13. Was Deceden If Yas, specify	t of Hispanic Origin? (S Cuban, Maxican, Puar No Specify:	Specify Yas or No to Rican, atc.)		a - Amarican India k, Whita, atc. Black	ก,
72 ho fical	-	15. Decedent's E (Specify only highast gr	ducation	1	6a. Decedent's Uaual C	occupation	dring	16b. Kind of Bu	sinass/Industry	
ad within 72 ho ygiene. wer than "natur 4, the Medical.	- Cultura	Elementary/Secondary (0-12)	Collega (1-4or 5	+) I	lifa. DO NOT usa lost Office	dona during most of wo retired) Clerk	ikii)g	Federal	Governer	nt
Mantal Hyg inhad other afic event, To Be C	17.	17. Fether's Nema (First, Middle, Last) Robert L. Green Sr.				18. Mothar's Na Geraldii		, Maidan Sumami I	e)	
od 2 shoulth and M 27 is mar 1 traumat		a. Informant's Name/Ralationship Cynthia Brown	(Type, Print)		19b. Mailing Address (S 1520 Ridge)
Pages 1 a ant of Ham at: If Ham: ry or othe	208	a. Mathod of Disposition 1 Burlal 2 Tramation 3 5 4 Donation 5 Other (Speci		cema	o of Disposition (Name atary, cramatory or othe sapeake Cre	r place)	Data 8-14-200	20c. Location	City or Town, Sta	
Departm Departm Importer eny injur	21.	Sommer Funeral Services	Duenni		22. Nama and A	Addrass of FacilityRol H Street N	pert O.	Freeman	Funeral	Serv
-	23	a. Part1. Enter the disease, or con shock, or heart failure. List on	unions that caused	the death I					Approx	
up physician and as the burial-transit	See if a can Ca tha	quentially list conditions, inv. leading to immediate use. Enter Underlying use (Disease or Injury ti initioted events sulting in death) Lest	b. ACG	CUL Dua to (or as	a consequence of): a consequence of):	SARC ALLINE	Africe	Ney Syn.	Month	
at the death cert by the attendin efsched for use Physician/N	Pai	1 II. Other significant conditions	dcontributing to death bu	ut not rasuitin	g in the underlying caus	sa gîvan in Part I.	23b. Dld	tobacco use con	ntribute to the ca	use of dea
igned by the be detached by Physic		CRYPTOCO	AL I	UAN	NB171	5	1 🗆	Yee 2000	3 Probably	4 Unkn
aw requir	-						24a. Was	s an autopsy ormed?	24b. Wara auto available p complation of death?	prior to
page Com	5						10	Yaa 2010	1 🗆 Yas	2 No
certific ector.		Was casa rafarred to medical axaminar?					ath (Check only	ona)		
5 6 0 M	2	1 Yas 2 No	Hospital: 1 Inpatia		Outpatient 3□ DOA	1	Y	idenca 6 Othe		
To To		Menner of Death	28e. Data of Injur (Month, Day	Year) 28	Injury	Injury at Work?	28d. Describe	how injury occurr	ed	
this ald		1 Natural 5 ☐ Panding	no.		M 1 ☐ Yas 2 ☐ No e. farm, street, factory, office 28f. Location			n (Street and Number or Rural Routa Number, Town, Stata)		
T.		1 Natural 5 Panding invastigation 3 Suicida 4 Homicide 6 Could not be determined	00 - 014 (-1)		, farm, street, factory, o	ffice	City or To	wn, Stata)		Number,
respons or Anending Physical Annual Physical Phy	27.	2 Accident 3 Suicide 4 Homicide a. Certifier (Check only 2 Medical Exe	28a. Place of Injudicing, atc	of my knowled	dge, death occurred at and/or invastigation, in	he time, data and plec	City or To	wn, Stata)	nnar as stated.	
Hespital or Attending Phys hours after death. Funerel Director: After this taly filled in by the funeral di Ical Certification: To	27.	2 Accident 3 Suicide 4 Homicide a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example	28a. Place of Injuding, atc	of my knowled	dge, death occurred at and/or invastigation, in	he time, data and plec my opinion, daath occ	City or To	causa(s) and ma dete end place, of	nnar as stated. and due to the ce	use(s)
as or Attending Physics after death. St Director: After this ed in by the funeral di Certification: To	27.	2 Accident 3 Suicide 4 Homicide a. Certifier (Check only 2 Medical Exe	28a. Place of Injudicing, atc	of my knowled examination ted.	dge, death occurred at and/or invastigation, in	the time, data and plec my opinion, daath occ icansa number	City or To	causa(s) and ma dete end place, of 29d. Data signed	nnar as stated. and due to the ce	use(s)
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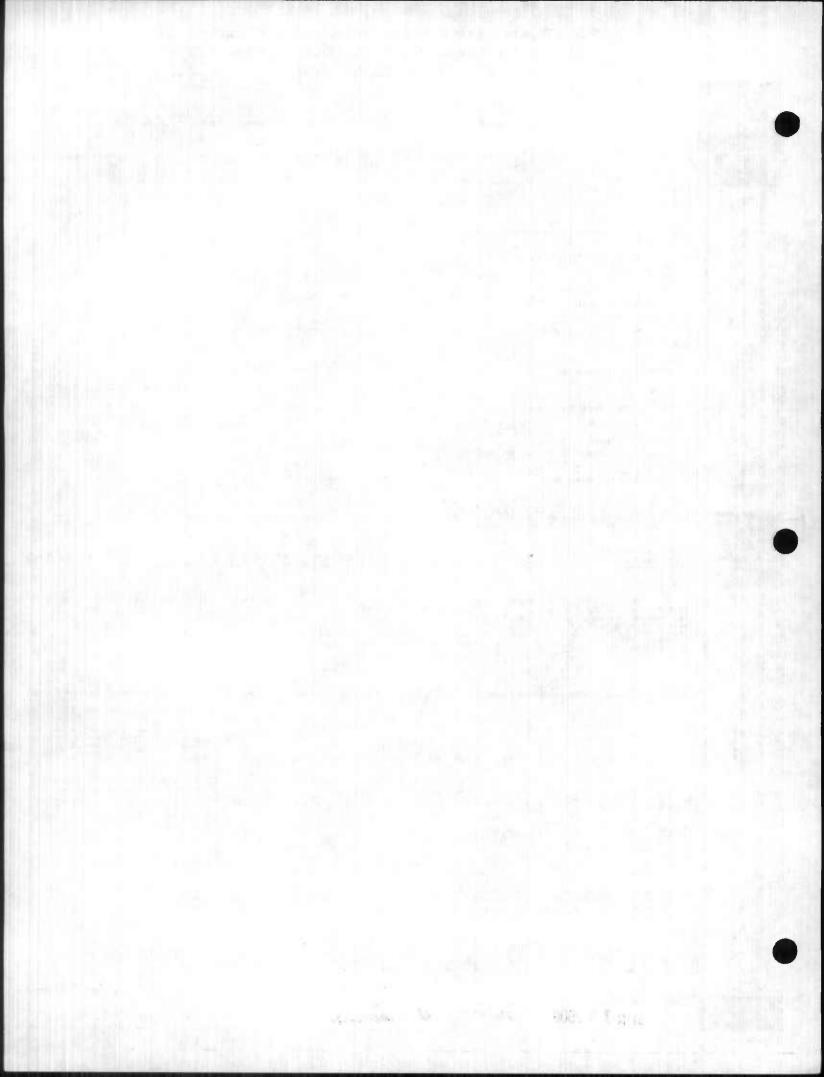
		Cert	tificate of	Death	Reg. No	o		
Physician /Medical	1. Decedent's Name (First, Middle, Lest) Eleanor C,	G	oter		Month De ugust 9	, 2000	3. Tima of Death 19:05 hr.	
Examiner	4a Facility Name (If not institution, give street and number) SHADY GROVE ADVENT 5. Social Security Number 6. Sex 7. Age	LLE	MONTGOMERY					
Funeral Director	5. Social Security Number 6. Sex 7. Age 1 M 2 F 8.4 Usual Residence of Decedent	(In yrs. last birthday)	Months Days	Hours Min.	Date of Birth Month, Day, Year, 10V • 15	915 MIN	place (State or Foreign intry) NESOTA	
with the Maryland a or 28a-f ahow be notified at	NC CLEVELAND CO.	10c. City, Town or Loc KINGS	ation MOUNT	AIN			10d. Inside City Limits 1 XYes 2 No	
3a or 28a-f	10e. Street and Number 606 HILLSIDE DRIVE		10f. Zip Code 280	86	10g. Ci	tizen of What Cou	ntry?	
72 hours after death with the Manaturelt, or Neurs 23a or 28a-f at Manaturelt, or Neurs 23a or 28a-f at Manaturelt Director Sted by Funeral Director	11. Marital Status 12. Was Decedent Evarmed Forces? 1 Never Married 2 Married 1 Yes 2 No H Yes, Give Year or Dates:		las Decedent of I Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ly Yes or No- can, etc.)	14. Raca - Ameri Black, White, Specify: WH	, elc.	
ithin	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k		during most of working d)		(ind of Business/Ir	idustry	
2 should be filed wand Mental Hygier is marked other th surratic event, the	17. Father's Name (First, Middle, Last) ELMER BERT CANAN	HOMEN	TAKER -		First, Middle, Maide	AT HOME iddle, Maiden Sumame) ZABETH THOMPSON		
and 2 should alth and Mer 27 is marks br traumatic	19a. Informant's Name/Reletionship (Type, Print) DR. CAROL GOTER-ROBINSON			end Number or Rural P				
emit. Pages 1 an Department of Heal Important: If Item 2 Iny Injury or other Ince.	20a. Method of Disposition ↑ Burlal 2 □ Cremation 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify)	ocalion - City or T	own, State NTAIN, NC					
permit. Pag Department Important: t eny Injury o page.	21. Signature of Funeral Service Licensee	SH.,DC						
Se as the bunal-transit	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	de to (or as a consequ	Melli- ence of):	farction tus	on		Onset end Death	
0 0 0	Part II. Other significant conditions contributing to death but	use contribute t	to the cause of death?					
requires that the death seen signed by the atten hould be detached for u			1 Yes 2 No 3 Probably 4					
The law requiras sate has been sign, page 2 should be					24a. Was an auto performed?	a	Vere autopsy findings vailable prior to ompletion of cause if deeth?	
certificate has b rector, page 2 s	25. Was case referred to medical			26. Piece of Deeth /	1 Yes 2 No 1 Yes 2 No			
Physician: this certifical director	examiner? 1 Ves 2 No Hospitel: 1 Inpatient		3□ DOA Oti	her:	5 Residence	6 □Other (Speci	ify)	
or Attending British death. Nector: After in by the funer in by the funer striffication:	27. Menner of Death 1 127Netural 5 Pending investigetion 3 Suicide 4 Homicide Pending investigetion 28a. Date of Injury (Month, Day) (Month, Day) 28b. Pleca of Injury (Month, Day) 28c. Date of Injury (Month, Day) 28c	v - At home, farm, sire	M 1	rk?]Yes 2□No	d. Describe how inju f. Location (Street e City or Town, Stel	nd Number or Rui	ral Route Number,	
Hospital 24 hours Funeral staly filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of e and manner state	xamination and/or inve						
To the comple	29b. Signature and title of certifier	llie m?		53244	Au		7, 2000	
(10)	30. Name and address of person who completed cause of dea Katharine R. Lillie, MD	ith (Item 23a) (Type, P 11140 Rock	rint) Eville Pi	Ke, PMB3	48, Rock	cville, N	(D 20852	
State Registrar	31. Date filed (Month, Day, Year) AUG 1 1 2000		ports	4. 1. 1.				

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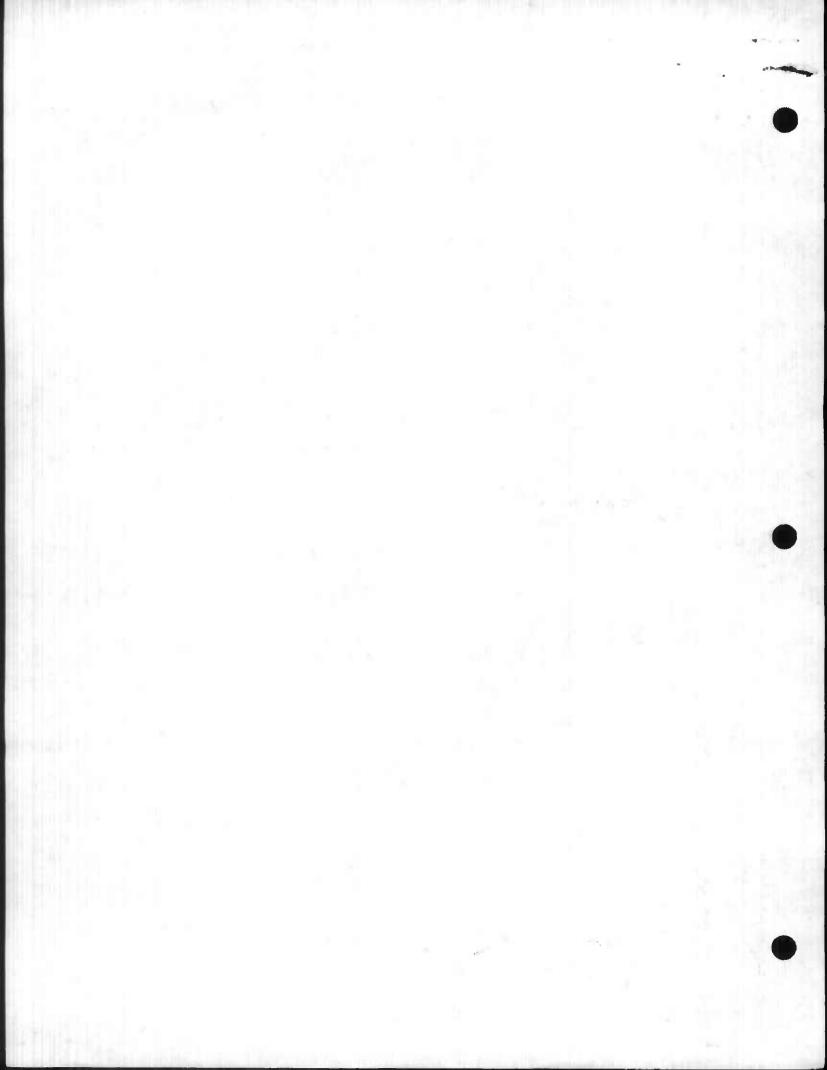
					Cer	tificate of	Death		Reg. No.	1 20/33
	Di		1. Decedent's Nama (First, Middle, La	st)	112 -20			2. Data of De Month		3. Time of Death
6	Physicia Medic/		SUSIE H.	GARRETT					8, 2000	5:46 AM
	Examin		4a Facility Name (If not institution, giv	re street and number)	100		4b. City, Town,	or Location of Deat	h 4c. County o	of Death
			WASHINGTON ADVENT	CIST HOSPITAL			Takoma	Park	Montgo	omery
	Funeral		5. Social Security Number 6. S		last birthday)	If Undar 1 Yaar Months Days		in. 8. Data of Bir (Month, Da	th IV. Year)	Birthplace (State or Foreign Country)
н	Director		423-32-6044	□ M 2 🛣 F	75 Yrs.	monno suje		May 6,	1925 A	Alabama
	2		Usual Residence of Decedent	140.00						
	aryte chow		10a. State 10b. County	10c. Cr	y, Town or Loc	cation				10d. Inside City Limits 1 ☑ Yas 2 ☐ No
	No M	ct	D.C. N/A	Wa	shingt	~				
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
	after deeth with the Maryler or items 23a or 28a-f show mires must be notified at		4212 3rd Street M				0011		U.S.A.	
	ep	Funeral	11. Merital Status	12. Was Dacedent Evar in U. Armed Forcas?	,S. 13, V	Vas Decedent of F Yes, specify Cub	lispanic Origin? an, Mexican, Pt	(Specify Yas or No uerto Rican, etc.)	- 14. Race Bleck	- American Indian, k, White, etc.
20			1 Nevar Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give	1	□ Yes 2☑ No	Specify:		Specify:	Black
00	"natural",	d by	3	Yaar or Datas:						
5	nat nat	Completed	15. Decedent's E. (Specify only highest gra	ducetion ade completed)	16e. Deced	lent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Bus	siness/industry
12	within ene.	E	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	House		5 /		N/A	
9	TI 70 1		17. Father's Neme (First, Middle, Last)	nouse	WILE	18. Mother's	Name (First, Middle	The second secon	
an	S E D	Be	Calvin Harris					Estelle		
7		2	19e. Informant's Name/Reletionship (Time Print)	10h Mailin	a Addrage (Street		Rural Routa Numb		Stale 7in Code1
Maryland 21215-0020	V 0 4 6		Iris B. Garrett			-		Columbia		
	tem 27 other tr		20a. Method of Disposition	20b. P	Plece of Dispos	sition (Neme of		Date		City or Town, State
Baitimore,	Pages nant of int: If Its iny or o		1 ☐ Burial 2 ☐ Cremetion 3 ☐	Hemoval from State		natory or other pla				
III	rtan rigur		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	LIL		n Nationa		8-16-00		on VA
Ba	permit. Page Department of Important: If I eny Injury or pncs.		21. Signature of Fulleral Service Close	1 100	1	Marshall	's Fune	ral Home,	Inc.	
			Julia .	Marshell				N.W. Was		
			23a Part Enter the disease, or com or heart feilure. List only	one cause on each line.	h. Do not ente	er the mode of dyli	ng, such as cer	diec or respiratory a	rrest,	Approximete Intervel Between Onset and Death
	Physician /Medical		Immediate Course (Final			11.	X			Orisot and Death
4100	Examiner		Immediate Cause (Finel disease or condition resulting in death)	. APTHIOSCLA) Las	17600	7 0	ISKASI	4	15 + 46ARS
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	be executed ician and buriel-transit	xar	Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying. Cause (Disease or injury	Due to (o	r es a consequ	uance of):				
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587	tificate ng phys as the	edical	resulting in death) Lest	Dua to (o	ras a consequ	uence of):				
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Вох	death cer e attendir ed for use	Physician/M						1		
0	es that the designed by the a	1ys	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	nderlying ceuse gr	en in Part I.			tribute to the cause of death?
0	5 90								Yes 2 No	3 Probably 4 thinknown
Records,	nequires een sign hould be	d by						24a. Was	en autopsy	24b. Wera autopsy findings
Ö	been s	ete							ormed?	available prior to completion of cause
Rec	has 96 2	Completed								of death?
	iclen: The le certificate ha rector, page							10		1 Yas 2 No
Vitai	icler certif recto	Be	25. Was case referred to medical examiner?	Hospital:	/	Ott	Jet.	Death (Check only		
of	Physiclen: this certific ral director,	-T	1 Yas 2 No	1 Inpatient 2 2	ER/Outpatien	3LI DOA	4 LI NUISI	g Home 5 Resi	how injury occurre	
	ing ing	No.	1 ☑Netural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 No	200. Describe	now injury occurre	FU
Sign	Attending r death. actor: Afte by the fune	Cat	2 Accident Investigation 3 Suicide 6 Could not b				Tes ZUNO	294 Location /	Ctreat and Number	er or Rurel Routa Number,
Division	or Al	Certification:	4 Homicide determined	28a. Place of Injury - At he building, etc. (Specification)	y)	eet, factory, office		City or To		or nurer noute runiber,
	the Hospital or hin 24 hours aft the Funeral Dir nplately filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	udadaa daath	nanumad at the ti	no data and st	and due to the	saura(a) and mar	and an elected
	Fun Fun etely	edicai		niner: On the basis of examine end manner steted.						
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	N	29b. Signature and little of certifier			29c. Licens	se number		29d. Date signed	1 (Month, Day, Year)
	H 3 H 8		ALA	MIN		111	291		^	0) ((1)
	(00)	-	20 Name and different of auto-	completed cours of death the	22a) (Fine 1	Point)) []		HUGUST	4,000
	(20)		30. Name and address of person who	Completed cause of death (Ren	D 1100	310 V	140.	1,000	MA MO	2020
	Stat	0	31. Date filed (Month, Day, Year)	32 Registrar's Signe	5 6 LC II	2	-7)	14.4110	ICIT I I'M	1010
	Registra		AUG 1 0 2000		9.	South	/			



State of Maryland / Department of Health and Mental Hygiene

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	Mary Mary and St.			Certi	ficate of	Death		Reg. No.		20104
Dhurisha	1. Decedent's Name (First, Midd	e, Last)					2. Date of D Month		Year	3. Time of Death
Physician /Medical	VANZULA		GRIFFI	N	-176			3/2000		5:00 PM
Examiner	4a Facility Nama (If not institution	n, give street end numbe	r)	+		4b. City, Town	, or Location of Dea	th 4c. Count	y of Death	
	WASHINGTON AI	VENTIST HOS	PTTAL.			TAKOMA			MONTO	COMERY
uneral rector	5. Social Security Number 111–26–0824		Age (In yrs. lest		If Under 1 Year Months Days			lay, Year)	9. Birth Cou LODO	place (State or Foraigntry) GE, SC
*	Usual Residence of Decedent 10a, State 10b, County		10c. City. T	Town or Local	tion					10d. Inside City Limits
notified at	MD	PG		ADELPH						¹X Yes 2□N
be notified Director	10s. Streel and Number				10f. Zip Code			10g. Citizen of	What Cou	nin/2
0 5 0	1801 METZERO	T ROAD		41	207	83		Tog. Onzui o	usa	
by Funeral	11. Merital Status 1 Never Married 2 Mar 3 Never Married 4 Divorced	If Yes, Give	s?] No	N Y	s Decedent of es, specify Cut	oan, Mexican, P	? (Specify Yes or N Puerto Rican, etc.)		AME	can Indian, RECAN
Completed		15. Decedent's Education (Specify only highest grade completed)			nt's Usual Occu	during most of	f working	16b. Kind of E	Businass/Ir	dustry
idu.	Elementary/Secondary (0-12)	Collega (1-4o	r 5+)	life. DO	NOT use retire	9d)				
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To Be Co	17. Fether's Name (First, Middle, GEORGE HAZEL	Last)				18. Mothers	Neme (First, Middle ELLA CA)		me)	
r traumatic e	19e. Informant's Name/Relations GAIL L. GARNI						or Rurel Route Num			o Code)
poortant: if hem by injury or othe nce.	20a. Method of Disposition © Burial 2 Cremation 4 Donation 5 Other (5		e PINE	e of Disposition of Communication of Com	ion (Name of tory or other place EMOR LAL	PARK	8/9/2000	20c. Location PINELA	- City or T	own, State
any injury	21. Signatura of Funeral Service	Licensee #CC002	73	22. N	lame and Addr		JOHN T. R. 3030 12TH			
sician edical	23a. P.u.f. Enter the disease, o mock, or heart failure. List immediate Causa (Final disease or condition resulting in death)		BOPU		LARY	ARR				Approximate Interval Between Onset and Death
attending priystican and for use as the bunal-transit clan/Medical Examinet	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	se se	PRICE	s a conseque EM [s a conseque GE P	A nce of):	. Buse	ASE.			
deteched for use	Part It. Other eignificant conditi	one contributing to death	but not resulting	ng in lhe und	erlying cause g	iven in Part I.		d tobacco use c		to the cause of death
signed to the det							-			
shour shour							24a. Wa	is an autopsy formed?	9	Vara autopsy findings vailable prior to ompletion of causa f daeth?
te has page 2							10	Yes 2 No	1	Yas 25 No
is certificate he director, page To Be Com	25. Was casa rafarred to medica					26. Place of	Death (Check only	ona)		
direction of the contraction of	axaminer? 1 ☐ Yas 2 ☑ No	Hospital:	tient 2 ER	NOutpatient	3 DOA	thar: 4 Nursi	ing Home 5 🗆 Re	sidence 8 🗆 O	ther (Spec	ify)
After th funeral flon:	27. Mannar of Death 1 Natural 5 Pending Invest		olury Day Year)	Bb. Time of Injury	28c. Inje	ury at ork? ☐ Yes 2 ☐ No		how injury occu	urred	
al Director: After ted in by the funers	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of I	njury - At home etc. (Specify)				28f. Location City or T	cation (Street and Number or Rural Route Number, ly or Town, State)		
To the Funeral Director: After this medical Certification: Medical Certification:		ng Physician: To the bes Examiner: On the basis and manner:	of axamination							
Me Me	29b. Signatule and the of certific				29c. Licer	nse number		29d. Dete sign	ed (Month	Dey, Year)
(6)	1 Depi	kg MD			Dr	+652	9	Augu	ST 4	2000
9	30. Nama and address of person	who complated causa of	death (Itam 23	3a) (Type, Pri	int)	ER P	ALKUAY	GRE	Sebe	2000 LT MARYLA
State Registrar	31. Date filed (Month, Day, Year, AUG 0 8 2000	Lienary 32. Regis	strar's Signature	home	161					



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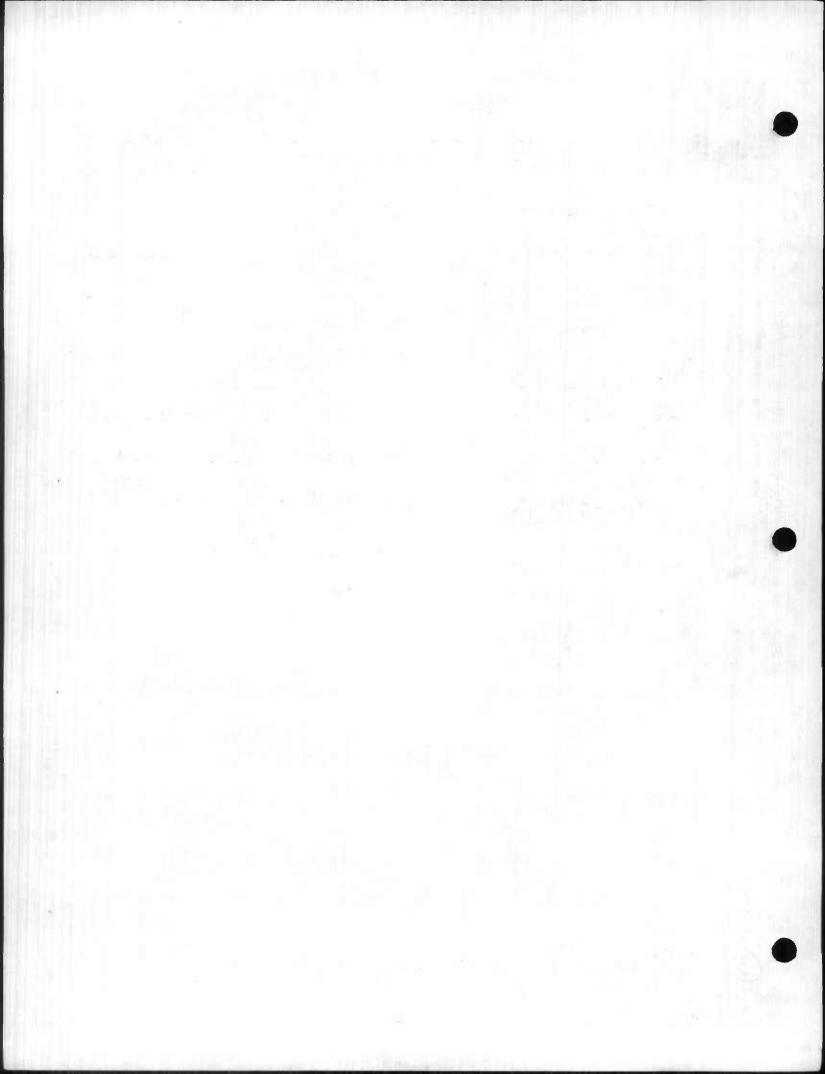
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	1. Dece	dent's Neme (First, Midd	dle, Last)						2. Date of Month		Day	Year	3. Time of Dea
ysician Medical	Juar	n Maghari G	onzal	es, Jr.					Jul				9:52 A
aminer	P-7-73	lity Name (If not institution		reet and number)			4b. City, Town, o	Location of D	eath	4c. County		
	110	00 Key High	way					Baltin				N/A	
eral ctor	N/	Security Number A esidenca of Decedent	6. Sex	7. A	ge (In yrs. le 42		If Under 1 Yeer Months Days	If Under 24 Hr Hours Mir	. (Month	Birth Day, Ye 26,	1958	9. Birthplac Country Phili	ppines
	10a. Sta	te 10b. Count	ly		10c. City	Town or Local	tion					10d	I. Inside City L
rector	Phi.	lippines	N/A		Ilo	ilo Cit	V						12 Yes 2
rec	10e. Str	eet and Number					10f. Zip Code			10g.	Citizen of V	Vhat Country	17
<u></u>	Mira	amar Compou	nd Bu	irgos St			N/A			Ph	ilipp:	ines	
by Funeral Director	1 🔯	tal Status Never Married 2 Ma Widowed 4 Divorce	rried	Armed Forces 1 Yes 2 H	Ever in U,S ? No		as Decedent of P es, specify Cub	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or rto Rican, etc.	No-		e · American k, White, etc	0.
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Physician/M		ither eignificant condit		lbuting to death	but not resu	iting in the unde	erlying cause gi	ven in Part I.	24a. \	Vas an a	2 No utopsy	3 Proba 24b. Ware eveil comported de	a autopsy findi able prior to pletion of ceus ath?
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 26736

			Certific	cate of l	Death		Reg. No.	20130
Physician	Decedent's Name (First, Middle, Last)					2. Dete of D		3. Time of Deeth
/Medical	Eda	Goldberg				August	3, 2000	12:00pr
Examiner	4a Facility Name (If not institution, give s Hebrew Home of Gre		on		b. City, Town, Rockvi	or Location of Dea .11e		of Death Itgomery
Funeral Director	5. Social Security Number 6. Sex 097-38-2476	7. Age (In yrs. last		Inder 1 Year oths Deys	Hours A	Ain. 8. Date of Bi	rth ay, Year) 27, 1909	9. Birthplace (State or Forei Country) Russia
wohow	Usual Residence of Decedent 10a. Stete 10b. County Maryland Montgome		Fown or Location					10d. Inside City Limi
or 28a-f all be northed Director		ily K						1 ½ Yes 2□N
or items 23a or 28a-f show critical must be mortified at Funeral Director	6121 Montrose Road	i	10	f. Zip Code 2085	52		10g. Chizen of W United	hat Country? States
9	11. Maritel Stetus 1 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:		ecedent of Hi specify Cuba es 210 No	spanic Origini n, Mexicen, Pi Specity:	? (Specify Yes or N uerto Rican, etc.)	o- 14. Race Black Specify:	- American Indian, c, White, etc. White
or then "netural", it, the Healen Em. Completed by	15. Decedent's Educ (Specify only highest grade		16e. Decedent's (Give kind o	Usuel Occupation	ation furing most of	working	16b. Kind of Bus	siness/industry
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saith and Men 127 is marke er traumatic TO	19a. Informant's Name/Relationship (Typ Doris Dorin/ Daugl		19b. Meiling Add			r Aural Aoute Numb	oer, City or Town, S ckville,	
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mportu any inja	21. Signature of Funeral Service Liganee	100	ss of Facility		rew Memo	rial Funeral		
attending physician and for use as the burial-transit clan/Medical Examiner								
d by the attend etached for us Physician/	Part If. Other eignificant conditions conti	ibuting to death but not resulting	ng in the underly	ing cause give	en in Pert I.	23b. Did	tobacco uee con	tribute to the cause of dea
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been s should				X.	128		s en autopsy ormed?	24b. Were autopsy finding available prior to completion of ceuse of death?
page 2						10	Yes 20 No	1 ☐ Yes 2 ☐ No
s certificate director, pag To Be Co	25. Was case referred to medical examiner?			0.5	. /	Deeth (Check only	one)	
H F	27. Megher of Death		VOutpatient 3E 3b. Time of Injury	DOA Othe	4 Nursir	ng Home 5 ☐ Res 28d. Describe	how injury occurre	
is after death. In Director: After the in by the funers Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	М	10	Yes 2 □ No		(Street and Number own, Stete)	er or Rurel Route Number,
Funer Funer tely fill	(Check only 2 Medical Examine	clan: To the best of my knowled er: On the basis of examination	dge, death occu	rred et the timation, in my o	ne, dete end pi pinion, deeth o	lece, and due to the	ceuse(s) end mer date end plece, e	nner as stated and due to the cause(s)
within 2 To the comple	29b. Signefure and tips of centiller	and menner stated.		29c. License	number		29d. Date signed	(Month, Dey, Year)
-	A1216	200 NO		7)/	808	4	August	03.2000
3)	30. Name and address of person who con	4	Say (Type, Print)	ONT	2058	RAR	DCN VIII	16/10/200
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Signeture		10/0 (1)	2032	10,10	UKVIL	LEM) 6088
Registrar	MG 0 7 2009 Sens	D. 1	carthe!					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** RAYMOND JOHN GRABIS AUGUST 11, 2000 6:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F Hours Director 219-16-1323 JULY 10, 1923 MARYLAND 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND ST. MARY'S **MECHANICSVILLE** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 38410 GOLDEN BEACH ROAD 20659 U.S.A. 12. Was Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 X Yes 2 No USN If Yes, Give Year or Dates: 1942-1946 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER 9 SELF-EMPLOYED 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN P. GRABIS BARBARA THERRES 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rlant: If Nem 27 GLENN JOSEPH GRABIS/SON P.O. BOX 476, CHARLOTTE HALL, MARYLAND 20622 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY 8/15/2000 CHELTENHAM, MARYLAND 21. Signature of Funeral Sociol Scenses 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. JPK Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) monthe Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Chronic Obstructive monary Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular disease ρV 24b. Were autopsy findings aveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? Gastritis 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) 1□ Yes 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Division of Vital Records. or Attending death. 24 hours after deat Funeral Director: To the Hosp within 24 ho To the Fune completely fi

Pages 1 and 2 should

Baltimore.

Health

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-45092 Parul Jani d cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 303 MD 206 redrick Hospital 31. Date filed (Month, Day, Year) AUG 1 5

State

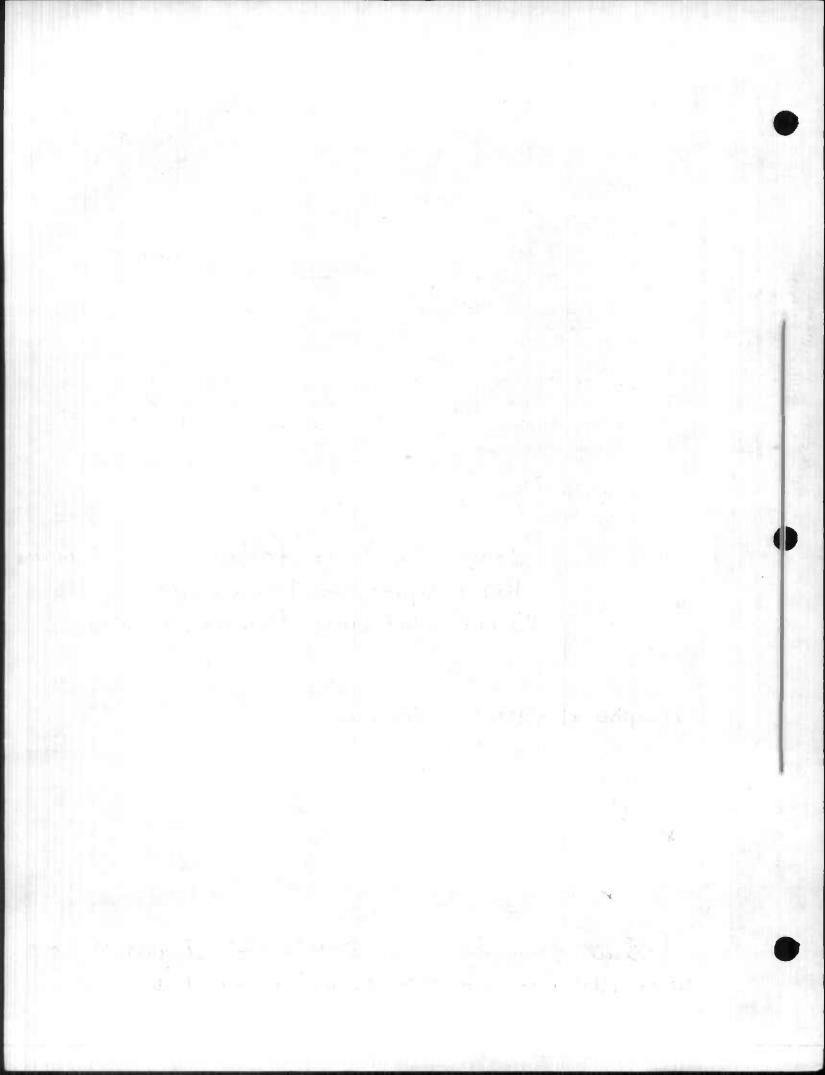
Medical

29a. Certifier

Registrar

DHMH 16 Ray 6/95

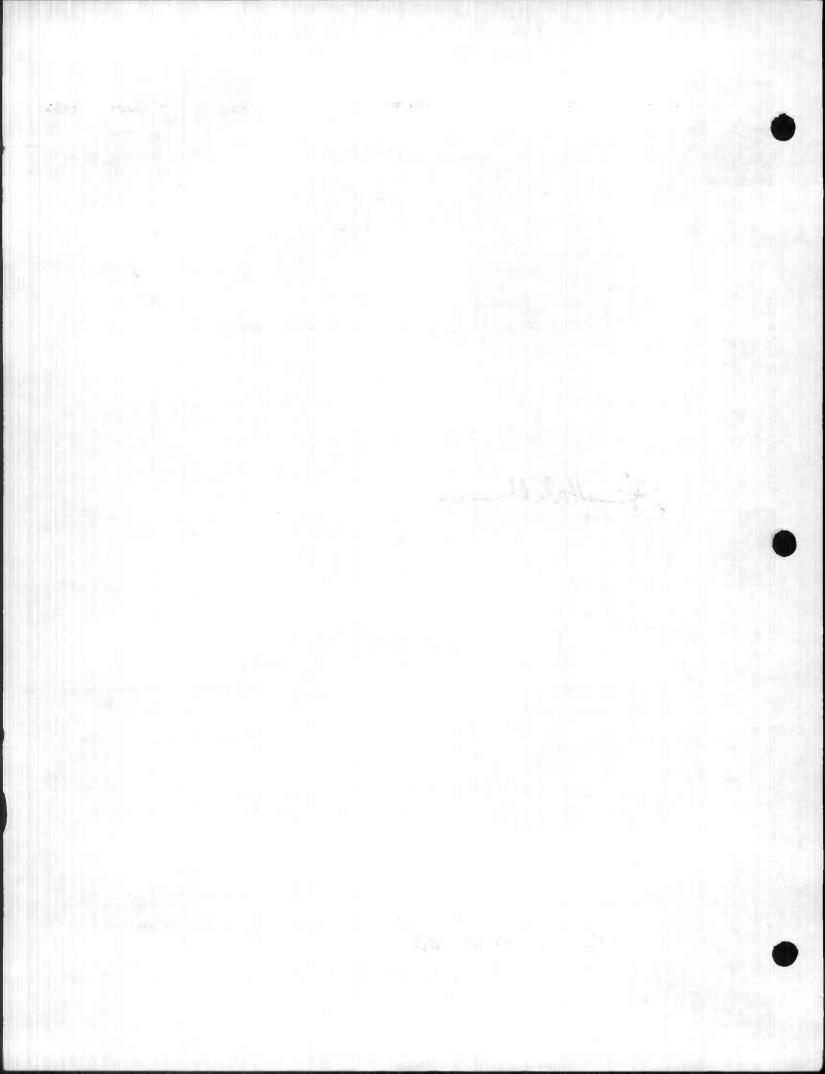
32. Registrar's Signature Denera



State of Maryland / Department of Health and Mental Hygiene 257

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Dhyololan		1. Decedent's Name	(First, Middle, La	st)					11-10-1		2. Dete of De Month	ath Day		Year	3. Tim	e of Death
Physician /Medical		Mary	S.		G	artlar	nd				August	8		2000	5:1	5AM
Examiner	_	la Facility Name (# 1 Wilson Hea							4b. City, To Gaithe		ocation of Deat	100		of Death		
Funeral Director	4	5. Social Security Nut 5.38-07-54	mber 6. S		7. Age (In yrs.	last birthda 84 yrs.	y) If Un Month	der 1 Year	If Under		8. Date of Bir (Month, Da Dec 11	th		9. Birthp Coun	•	te or Foreign
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tiled within 7.2 hours eiter deem with the marylend Hygiene. Hygiene. Sint, the Medical Examiner must be northfled at eit, the Medical Examiner must be northfled at e. Completed by Funeral Director		37.53.1	10b. County			ty, Town or								1		e City Limits
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23a or 2 wat be n		10e. Street and Numl					20	Zip Code 877				Unit	ed	What Cour State	es	
ral', or iteme 23a or 28a-f ahow Examiner mart be nortified at 5 by Funeral Director		11. Marilel Status 1 □ Never Married 3 □ Widowed 4		12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 □ No	I,S. 13		cedent of pecify Cut			ecify Yes or No Rican, etc.)			ce - Americ ck, White, 'Y'-),
or than "natural", t, for Medical Exist Completed by		(Specify	5. Decedent's Ed y only highest gra dary (0-12)	ducation de completed) College (1	-4or 5+)	(Git	edent's U ve kind of DO NOT		pation during mos ed)	t of work	ing	16b. Ki Own		usiness/Ind	dustry	
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f Health and Men tem 27 le marke other traumatic		19a. Informant's Nan	ne/Relationship (Type, Print)		19b. Ma	iling Addre	ess (Stree	t and Numbe	er or Run	al Route Numb	er, City o	r Town	, State, Zip	Code)	
Health a tem 27 le other trai	1	Mary Emeri	c /Daug	hter		6301	Ste	venso	n Ave	. #7:	10, Ale	xand	ria	, VA	2230	4
Department of Health a Important: If Item 27 is any Injury or other training.	20e. Method of D 1 Burial 4 Donation	20e. Method of Dispo 1 Durial 2 4 Donation 5	Cremation 3 [Stete	Place of Discemetery, co	rematory o	or other pla	,	8	Dete - 10-00			City or To		•
Depentimportures any Injuria.	1	21. Signature of Fund	mal Service Lices	300 UE			22. Name Rapp 933	end Addr Fune Gist	ess of Facili eral & Avenu	Cre e S	mation ilver S	Serv	rice	es MD		
nysician		23s Part Enter the shock, or heart	disease, or com failure. List only	plications that cr one cause on er	aused the dea ach line.	th. Do not e	nter the m	node of dy	ing, such as	cardiac	or respiratory a	rrest,			Approxi Intervel Onset a	mate Between nd Death
/Medical		Immediete Cause (Fi	inal	Pneum	onia										1 da	У
taminer		resulting In death)		Due to (or as a consequence of): Dementia Years									s			
in end hel-transit Examiner		Sequentially list cond if any, leading to immo cause. Enter Underly Ceuse (Disease or In that initiated events	dillons, nediate	or es e consequence of):												
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ned by the ettendi e detached for use y Physiciary		Pert II. Other signific Hyperten						g cause g	iven in Part I			Yes 2				se of death?
page 2 should be c											24e. Wes	en eutor ormed?	osy	ev	ere autor vailable prompletion death?	esy findings for to of cause
page 2											10	Yes 21	S No	10	Yes	Z No
this certificate ral director, par		25. Was case referre	d to medical						26. Plece	e of Deat	h (Check only	one)				
To B		examiner? 1 Yes 20 N	o	Hospital: 1 I	npatient 2	ER/Outpat	ient 3	DOA O	ther: 4 No	ursing Ho	ome 5 Resi	idenca	6 🗆 Ot	her (Specif	fy)	
		27. Manner of Death 1⊈ Neturel 2 ☐ Accident	5 Pending investigation	1	f Injury h, <i>Day Year)</i>	28b. Time Injury		28c. Inju We 1	uryat ork? ⊡Yes 2 ^X ⊡		28d. Describe	how injur	y occu	rred		
Olrect in by		3 Suicide 4 Homicide	6 Could not be determined	259. Place	of Injury - At h ig, etc. (Speci	ome, farm, :	street, fac	tory, office			28f. Location (City or To	Street an wn, State	d Num	ber or Run	al Route i	Vum <i>ber</i> ,
n 24 hound he Funer pletely fill edical			Certifying Ph Medical Exam		sis of exemina											se(s)
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 8, 2000 Year **Physician** Lewis David Gelfan 6:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Country)
Sept. 22, 1920 California 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Months Hours 1⊠M 2□ F Yrs. 092-18-8232 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits shon 1 Tes 2X No Directo Maryland Montgomery Bethesda "natural", or flams 23s or 28s-f result be notifie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 8304 Lillystone Drive 20817 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Bleck, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White À 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filled within Federal Aviation Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Writer/Editor 5+ Administration 17 Father's Name /First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Pages 1 and 2 should be Ill ment of Health and Mental Heart; if Item 27 is marked oil jury or other treumetic even Be William Gelfan Bess Bock 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 904 Gilbert Road, Rockville, Maryland 20851 Ingrid Bess Ivins/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State August 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc. 9, 2000 Bethesda, Maryland R²² Name and Address of Facility of Suneral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee 0 M00198 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical Pneumonia 1 week Examiner Due to (or as a consequence of) Examiner Hemorrhagic Stroke the death certificate be asscuted physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2K No 3 Probably 4 Unknown signed b Records, à 24b. Were autopsy tindings available prior to completion of cause of death? been signature 24a. Wes an eutopsy performed? Completed The law page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Division Attending 1 Netural death. 1 ∏Yes 2 ∏No To the Hospital or Attendity within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. (Check only one) miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

+ 10

> 31. Date filed (Month AUG State Registrar

29b. Signature and

30. Name and address of person who complet

Walter E. Goozh, M.D.

11 2000 32 Registrer's Signature

ed cause of death (Item 23a) (Type, Print)

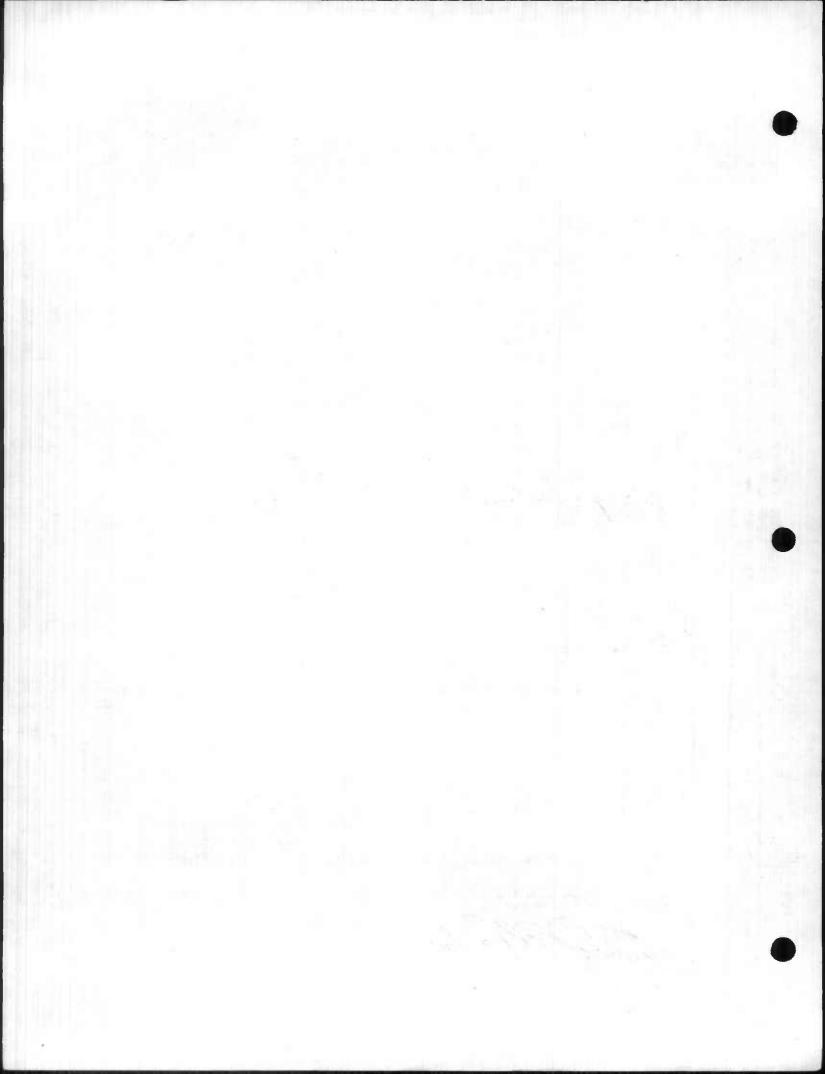
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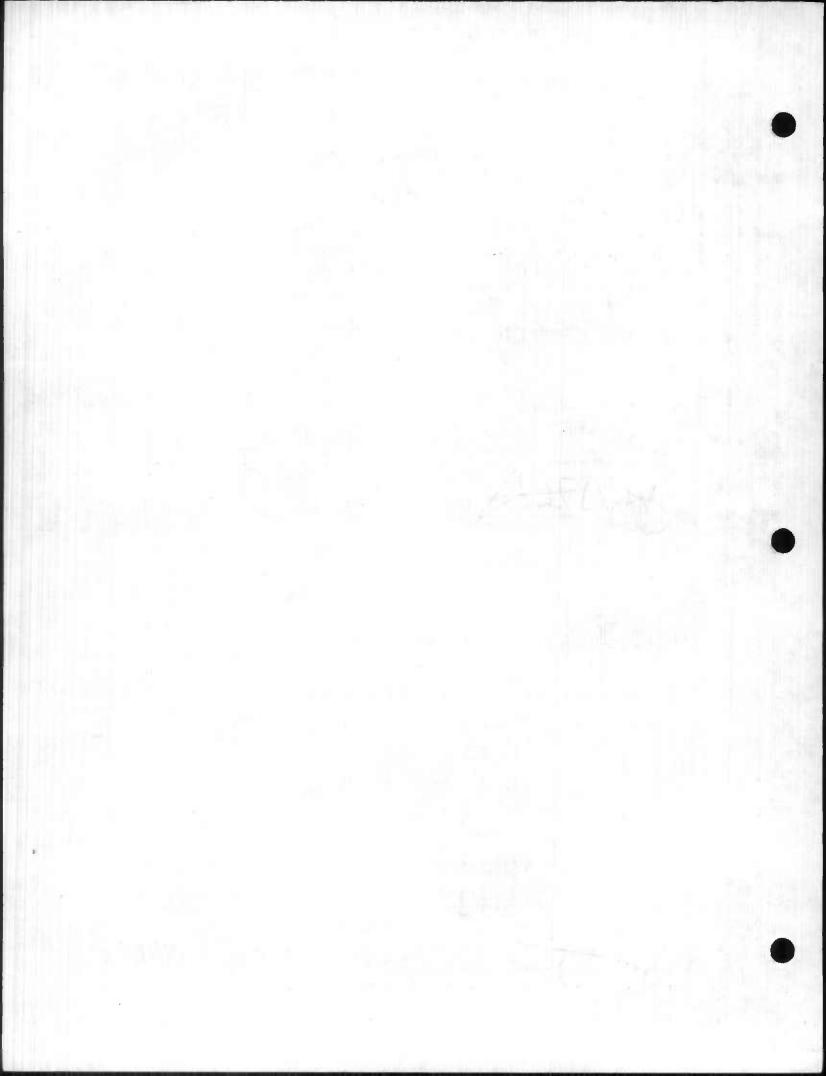
29d. Date signed (Month, Dey, Year)

August 8, 2000



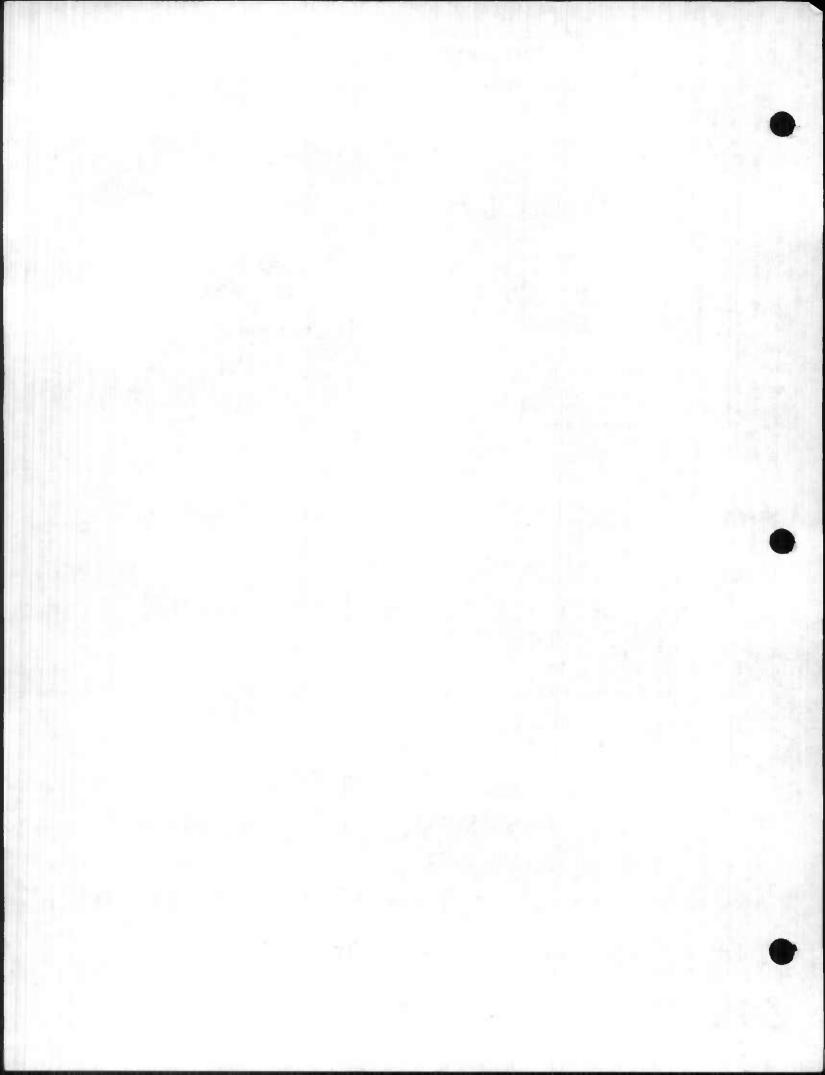
State of Maryland / Department of Health and Mental Hygiene 26740 Certificate of Death 1. Decedenl's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Day **Physician** Jean M. Gentile August 1, 2000 8:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 20 F 69 June 24, Director 579-38-0859 1931 Washington, D.C. Usual Residence of Deceden Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or frame 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Germantown the 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 20408G Shore Harbour Drive 20874 United States death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within? Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than "gen jujury or other traumatic event, in a tendomica. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Bank 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be James Craig Julia Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Christy L. Enrico/Daughter 12755 Lime Kiln Road, Highland, Maryland 20777 6 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Date 20a. Method of Disposition 20c. Location - City or Town, State Aug. 4, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Rockville, Inc. M00689 Rockville, Maryland 20850-2 Ro Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) . Renal Cell Cancer Examiner Due to (or as a consequence of): Examiner physician and the burial-transit requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 for usa as USB 23b. Did tobecco use contribute to the cause of death? P.O. ed by the a Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by i 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? been s 24a. Was an autopsy Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartilicata Division of Vital Attending Physicien: director, 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 Yes 2 No Certification: To this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending ne Hospital or Attending n 24 hours after death. Ne Funeral Director: After pietely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the Comple 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certified IN 8/1/60 MD D0054378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aylesworth, M.D. 6800 Georgia Avenue, Washington, DC 20807 Cheryl 31. Date filed (Month, Day, Year) AUG 0 7 32. Registrar's Signature State mer -Registrar



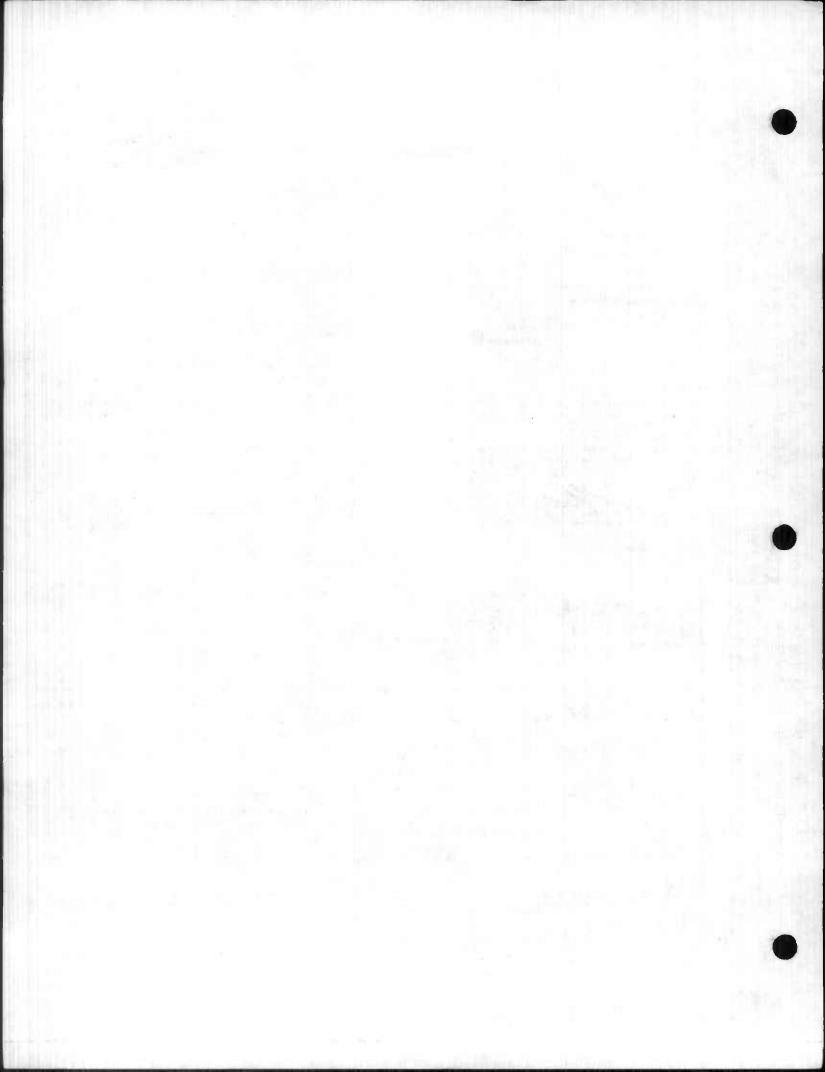
State of Maryland / Department of Health and Mental Hygiene 00 2674

				C	ertifica	te of	Death			Reg. No.		401	1 -1	
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The state of the s	kaminer	4a Facility Name (If not institution, give	street and number)				4b. City, Tov	wn, or Lo	cation of Deat	h 4c. Count	y of Death			
Sal		5101 River Road	#1404				Bethes	sda		Montg	omery			
	neral ector	014-01-1463	9x 7. Age (In) □ M 2△F 82	rs. last birthde Yrs.	y) If Under Months	or 1 Yeer Days		24 Hrs. Min.	8. Date of Bir (Month, Da Jan • 2	1918 Yell'918	9. Birthp Mass	ace (Stete	e or Foreign setts	
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to Maryte	be notified at Director	Md. Montg		•	Bethes							1 [™] Ye	s 2 No	
23a Or 2	1 10	10e. Street and Number 5101 River Road	#1404		10f. Z	ip Code 208	316			10g. Citizen of USA		try?		
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, Maryland 21215-0020 and 2 should be liked within 72 hours at leth and Mental Hygiene. 37 is marked other than "natural", or	er traum	19a. Informant's Name/Relationship (7 John Gorman/nephe								er, City or Town				
Sattimore semil. Pages 1. Separtment of He moortants if liam	ury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	b. Placa of Dis com <i>etery</i> , c Calvary	rematory or	other pie		,	ug.10,	20c. Location Brock	- City or To			
Demit. Depart Import	any inj	22. Name and Address of Facility De Vol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 2 23 And Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Interest, or heart failura. List only one cause on each line. Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Interest.												
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		30. Name and address of person who collin D. Cullen	, M.D., 5454 W	isconsi	e, Print) .n Ave	.,#	1625,	Che	vy Chas	e, Md.	20815			
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State of Maryland / Department of Health and Mental Hygiene 00 2671.2

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Examiner	SUBURBA	N HOSPITA	L					BETHESDA	A	N	ONTG	OMERY	7	
Funeral Director	5. Social Security 563-52-4 Usual Residence	1428	Sex 1 M 2 F	7. Age (In yrs.	9 Yrs.	Months	Deys		fin. B. Date of B. (Month, D. FEB 14)	ay, Ya	31	9. Birth	plece (State o	r Foreign
show ed.st	10a. State	10b. County		10c. Ci	ity, Town or	Location						1	10d. Inside Ci	
or 28a-f sho be notified at Director	MD	MONTGOME	CRY	BEI	THESDA								1½ Yes	2 No
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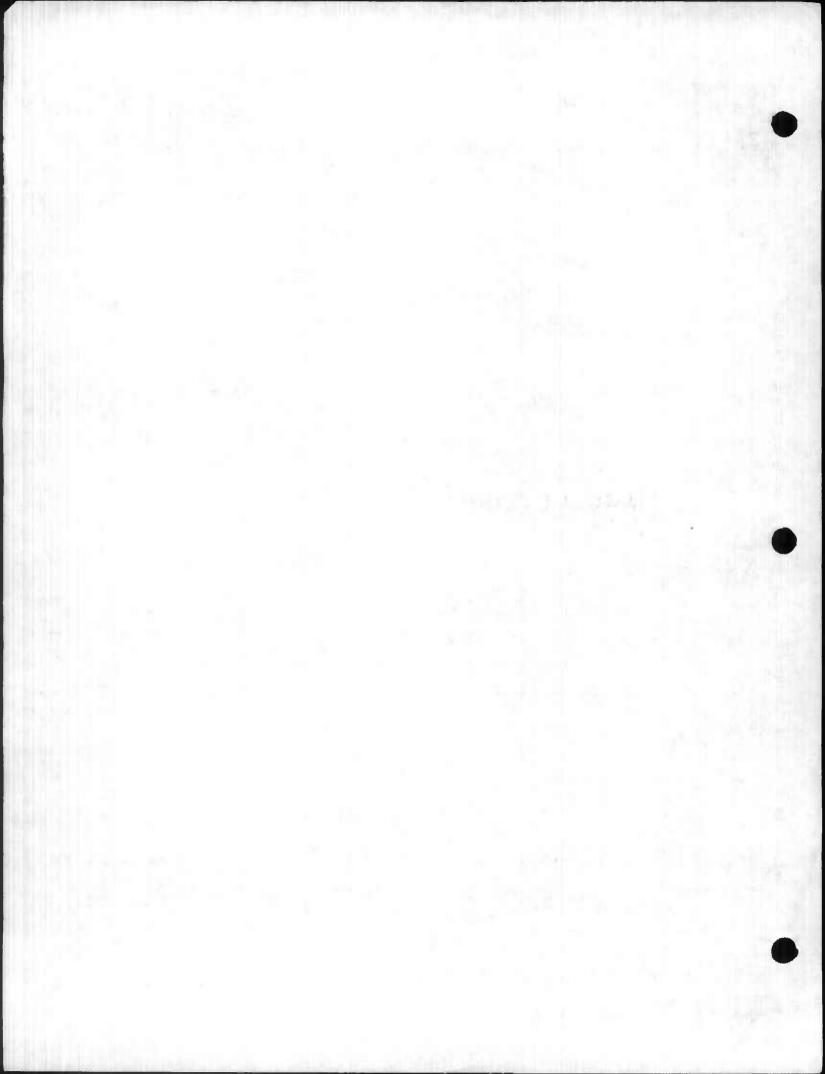
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certif	icate of	Death		Reg. No.	0 20/43
Physician /Medical	1. Decedent's Name (First, Middle, Las	CO				2. Date of D	1 31, 20	3. Time of Death 12:50 AM
Examiner	4a Facility Name (II of institution, give Avunde	el Medical	Center		4b. City, Town, or HIN app	olis	Ann	e Arundel
uneral irector	099-44-7304	7. Age (In yrs.		Under 1 Year onths Days	Hours Min		12, 1952	9. Birthplace (State or Foreign Country) 2. New York
ladat tor	Usual Residence of Decedent 10a. State 10b. County New York Otsego	10c. Ci	ity, Town or Location	on				10d. Inside City Limits 1 Yes 2 No
be notified Director	10e. Street and Number			Of. Zip Code			10g. Citizen of W	/hat Country?
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B Be	17. Father's Name (First, Middle, Last)	5+	Veterina	rian			Animal e, Maiden Sumam	Health Care
To	Nunzio Greco 19a. Informant's Name/Relationship (7)					ural Route Num	ber, City or Town,	
ary or other to	Jennifer Greco/Dat 20a. Method of Disposition 1 Burial 2XX remation 3 4 Donation 5 Other (Specify	Removal from State	230 Woo Place of Dispositio cometery, cremato llington	n (Name of ry or other pla	ce)	ilmingto Aug 4, 2000	on, NC 28	City or Town, State
iclan	21. Signature of Funeral Sarvice Licen-	blications that caused the daa one cause on each line.	5517 th. Do not antar th	Vine a moda of dyi	Street,	Alexand	ria, VA 2	Approximate Inflavoral Between Onset and Death
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has been s ge 2 should mpleted						per	s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
certificate rector, pa	25. Was case referred to medical examiner?		/		26. Place of De	ath (Check only	- 1 - 1 - //- //	10163 2010
50 D	1 d Yes 2 No	Hospital: 1 ☐ Inpatient 2 1	ER/Outpatient	BDOA O	her: 4 Nursing	Home 5 Re	sidence 6 DOth	er (Specify)
After the funera	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 □ No	28d. Describe	how injury occur	red
Director: A lin by the fi ertificati	3 ☐ Suicide 6 ☐ Could not be						400 . 4	er or Rural Route Number,

29c. License number 128640

Jeffrey Beiggs, M.D 31. Data filed (Month, Dey, Yeal)
AUG 0 7 2000

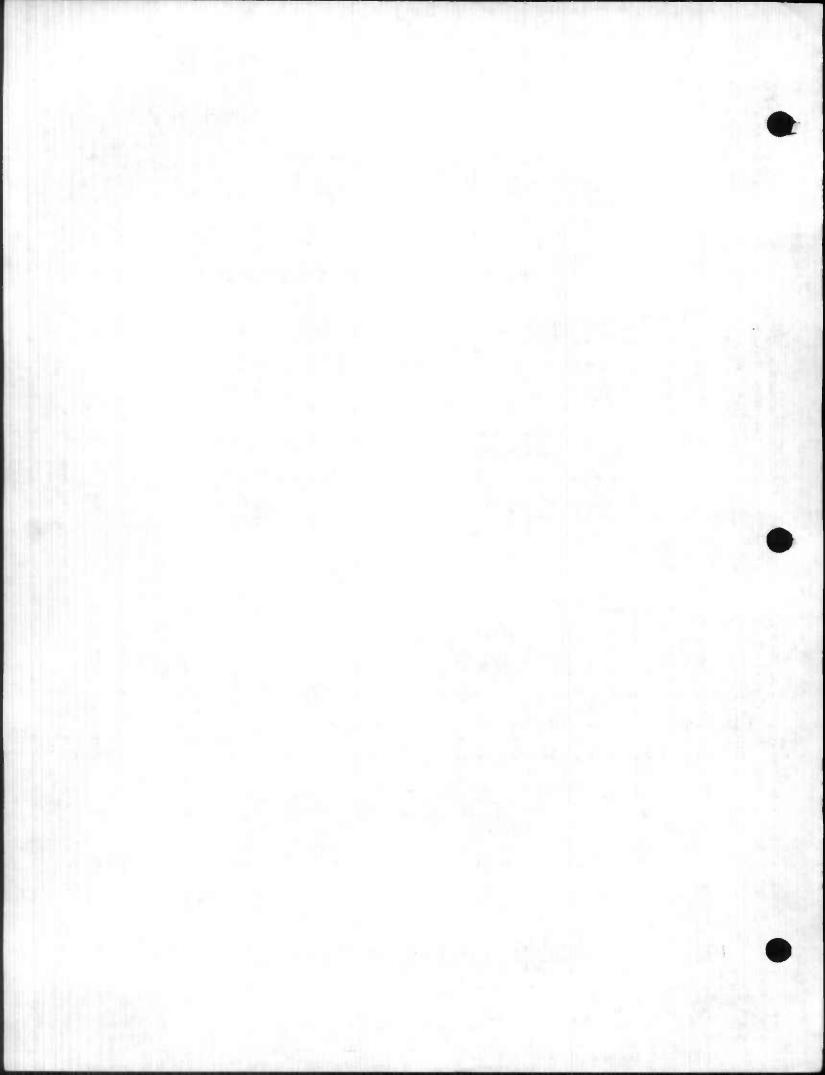
State Registrar



State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, La			Certifica		Death		leg. No.	UO	26744 3. Time of Death
Physician	1. Decedent's Name (First, Middle, La	ist)					Month	Day	Year	3. Time of Death
/Medical	Irene Margaret Gr					4b. City. Town, or L	August	9, 2000		6:54 am
Examiner	4a Facility Nama (If not institution, given	/a street and number)						4c. County of		
N2. 11 7	Holy Cross Hospit			tin a Him	dar 1 Year	Silver Sp		Montgo		
Funeral Director		Sex 1□M 2OXF	e (In yrs. last	Yrs. Month			8. Date of Birth (Month, Day Jan 6,		New New	ace (State or Foreign ry) York
death with the Maryland ma 23e or 28e-f show mass be notified at neral Director	10a. State 10b. County	300	10c. City, To	own or Location					10	d. fnside City Limits
with the Maryls to 23se-f ehor	Maryland Montgome	ry	Wheat							1 ☐ Yas 2 XNo
or 2	10e. Street and Number			10f.	Zip Coda		1	l0g. Citizen of W	hat Countr	у?
ath wath 23a	3001 Weller Road				0906			JSA		
5 22 3	3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yas, Give Year or Datas:			pecify Cub	dispanto Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Specify:	- Amarica k, White, et	tc.
Maryland 21215-0020 d 2 should be filed within 72 hours after th and Mental Hygiene. 77 le marked other than "naturel", or he traumatic event, the Madical Emirina To Be Completed by Fu	15. Decedent's E (Specify only highest gra-	ducation ade completed) College (1-4or !		6a. Decedent's U (Giva kind of life. DO NO	work done	during most of work	king	16b. Kind of Bus		
nd 21; silled wit til Hygiene other tha vent, the	12		F	Executiv	e	40 46-41-4-41-41	- 4574 h 41-d-41-	Federal		ernment
Maryland d 2 should be filed to and Mental Hyg 7 le marked other traumatic event,	17. Father's Nama (First, Middle, Last					18. Mother's Nam	a (First, Middle,	Malden Sumame	9)	
should be of Mental marked o marked o To Be						Mary Kat				
Mary 42 shouth and M	19a. Informant's Name/Relationship	•				l and Number or Ru			State, Zip (Zode)
other 27	Homer E. Grizzard	/ Husband	20h Plane	3001 Wel	ler R	oad, Whea		20906 20c, Location - 0	City or Toy	um State
TO Page	20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special			of Disposition (letery, crematory of John's			/11/00			
Baltir permit. P Departme Importan any injur	21. Signature of Funeral Service Lice	See Bal		Fran	cis J	• Collins				g, MD 20901
Examiner or a specular or a special or a specular or a spe	timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Coronary	Due to (or as	a consequence	of): se					
ficate be physicians the burner and call call	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as	a consequence of	of):	ular Dise Mellitus				
O. F. the dea	Part If. Other algnificant conditions of	contributing to death b	ut not resultin	g in the underlyin	g cause gi	ven in Part I.	23b. Dld t	obacco usa con	tributs to	the causs of death?
ds, P.O.	Chronic Renal Ins	ufficiency	7				101	/es 2□ No	3 Prob	ably 45 Unknown
Recor	Stroke, Nonhemorr	hoghic, Bil	nemisph	eric			24a. Was a perfor	7 4	ava	re autopsy findings ilable prior to apletion of cause leath?
Vital Relation: The la rector, page:							1 U Y	es 2 X No	10	Yas 2 No
Vita	25. Was case referred to medical examiner?	Hospital:			0.		th (Check only or	ne)		
C B age of	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry 28	/Outpatient 3☐ b. Time of Injury	28c. Inju		ome 5 Resid	lence 6 □Othe now injury occurr)
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director Affect to ompletely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	200. Place of Inj	ury - At home c. (Specify)	, farm, streat, fac	tory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural	Route Number,
ne Hospit n 24 hour ne Funera pletaly filli	29a. Certifier (Check only one) 1 X Certifying Pt 2 Medical Example 1	nyelclan: To the best miner: On the basis o and manner st	f examination	dge, death occurr and/or investigat	red at the ti	ime, date and place opinion, death occu	, and due to the c rred at the time, c	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
To the virbin of the state of t	29b. Signature and title of comme	pho	- 1	.0		1583°		29d. Date signed	Month, C	hay, Year)
	30. Name and address of person who	Ful	leath (Item 23	(a) (Type, Print)		ond Ave #		1,,,,,		MD
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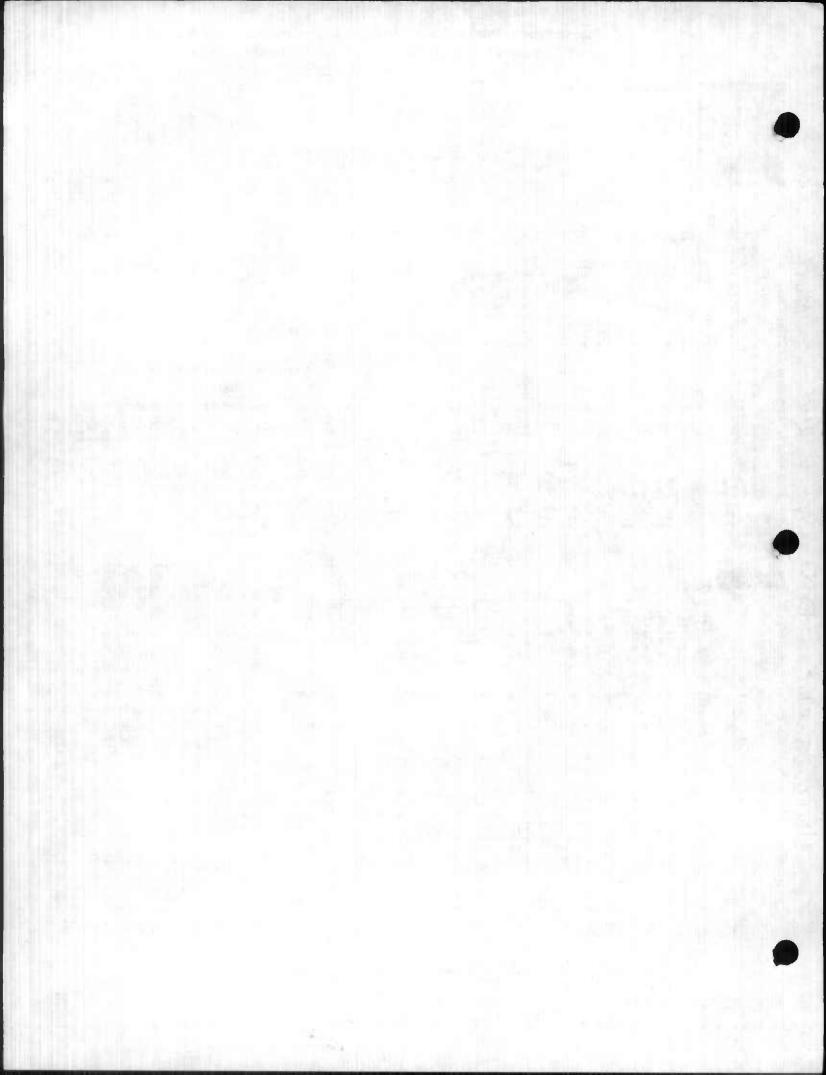
nt of Health and Mer	ntal Hygiene	00	267
te of Death	Reg. No.	00	401

						Certifica	te of	Death	R	eg. No.	00	20/45
			1. Decedent'a Nama (First, Middle, Li	est)		0.00			2. Date of Deal			3. Tima of Death
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5 4	LAGIIII	ici	Southern Ma	ryland Hosn	oital C	enter		Clinto	n	Princ	e Ge	orge's
	Funeral			-	(In yrs. last bi		er 1 Yaar	If Undar 24 Hr				placa (State or Foreign
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	after death with the Maryland or items 23s or 23s4 show incline must be notified at	Director		George's	Upper	Marlbo				0- 0		t □Yas 2XXVo
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	23 ath	Funeral	7010 Woodyard R			10.141		20772	C		ISA	an tadion
	ar de	un	11. Marital Status	12. Was Decedent E Armed Forcas?		If Yas, sp	ecify Cube	an, Maxicen, Pua	Specify Yes or No- rto Rican, atc.)		k, Whita,	can Indian, atc.
Maryland 21215-0020		by	1 Never Married 2 Married 3 Widowed XXDivorced	1 ☐ Yas 2XXVI If Yas, Giva Year or Dates:	0	1□ Yaa	¾ QXNo	Specify:		Specify	. Whi	te
5-0	n 72 hours "netural", o cal Eur	Completed	15. Decedant'a E (Specify only highast gr		18a	. Decedent's Us	ual Occup	ation during most of w	orkina	16b. Kind of Bu	sinass/In	dustry
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2	22 00 10	Son	12	Ø		Jockey .	Agent			Race	Trac	k
Pu	m = 0 =	Be	17. Father's Nama (First, Middla, Las	")				18. Mothar's Na	ıma (First, Middle, I	Maiden Sumam	a)	
ia	should be and Mentel marked o	2	Nuncy Greco					Joseph	ine LaRos	a		
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	ges 1 and 2 should it of Heelth and Mer if frem 27 is marks or other traumatic		Joseph Edward Gr	eco/Son	7	890 Ame	ricar	na Circle	e, Apt T3	, Glen	Burn	ie, MD 21060
ore	Ren oth		20a. Mathod of Disposition		20b. Place o	d Disposition (N	ama of other plac	ce)	Data	20c. Location -	City or To	own, Stata
Ĕ	Pages nent of t		XXBurial 2 Cremation 3 (4 Donation 5 Other (Speci						8/15/00	Baltim	ore,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 le eny Injury or other tra-		21. Signature of Funeral Service Lice	2000				ss of Facility	onaldson			
	40500		XIW Iff Line	MAL MOO	0773	313 т	albot	t Avenu	e, Laurel	, MD 20	707	
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	Physician		0/									Onsat and Death
di.	_/Medical		Immediata Causa (Final disaase or condition	Anos	416	ENCE	Pusi	platny				
	Examiner		resulting in death)			consequence of	1):	Vining			E.	
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	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions,	b	Dua to (or as a	consequence of):	- / 15 1				
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Вох				d		1111111						
	0 0 0	Physician/	Part fl. Other significant conditions	contributing to death but	not resulting I	n the undarlying	ceuse giv	ran in Part I.	23b. Did to	bacco use co	ntributs t	o the cause of death?
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		by	13RAN	Alsserss								
of Vitai Records,	been s	Completed t	ALCOHOL	ABUSE					24a. Was a perform	n autopsy med?	av	fere autopsy tindings vailable prior to empletion of cause death?
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ā	certificate he rector, page	ပိ							1 🗆 Y		1	Yes 2 No
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o	Physicien: this certific ral director,	2	1 Yas 2 No	1 La Inpatiar			JUA	4 LI Nursing	Home 5 Raside			fy)
5	After funer	On	1 ⊠Natural 5 Panding	28a. Data of Injury (Month, Day		Tima of Injury	28c. tnjur Wor		280. Describe n	ow injury occur	180	
Sic	Attending or death. actor: After by the fune	cat	2 Accident investigation 3 Suicida 6 Could not 1	A		М		Yas 2 □ No				15 1 1
Division	or Attendation death Director:	Certification:	4 Homicide determined	28a. Place of Inju building, etc.		arm, street, facto	ory, office		City or Town		er or Hun	al Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	edical	29a. Certifiar 1 Certifytng (Check only one) 2 Medicat Exe	mystcian: To the best of mirror: On the basis of and mannar stat	axamination ar	a, daath occurre nd/or investigation	d at tha tir on, in my o	ne, date and place pinlon, death occ	e, and due to tha courred at tha time, d	ausa(s) and ma lata and place,	innar as s and due t	stated. o tha cause(s)
	omp omp	Me	29b. Signatura and titla of corpor	//		2	9c. Licans	a number	2	9d. Data signa	d (Month,	Day, Year)
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	2		20 Name and address of severy fire	completed source of div	ath /ltam DOct	(Tune Daine)				-1	,	
		- 1	30. Nama and addrass of person who	AWAW 75		MATTS	los	\$ # 307	CLINTOI	v Mb	20	735
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	Reaist		AUC 15		we	4	1.					

DHMH 16 Ray 6/95

8-10-00 LYP @ 2155 FM

Dreco, Frank #



State of Maryland / Department of Health and Mental Hygiene 00 26746

	Certificate of Death		Reg. No.	20140
	Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
Physician /Medical	GEORGE HAYES	80	08 20	0
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death	4c. County of De	ath 100
	Prince Georges Hospital Center Chaverl	7		PG
Funeral Director		8. Date of Birt (Month, Da June 14,	y, Year) 9. B 1935 (inthplece (State or Forei Country))klahoma
2 .	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
aryta ash				1 X Yes 2 □ N
or 28a-f s be natified Director	Maryland Prince George's Bladensburg			
th with the said ble or all Directions	10e. Street and Number 10f. Zip Code 20710		10g. Citizen of What (country r
South True 2	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Spering of Yes, specify Cuban, Mexican, Puerlo)	city Yes or No	14. Race - An	nerican Indian,
at, or the Example Dy Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 1 Never Merried 2 Married 1 Yes 2 No 1 Yes, Sipe 1 Yes, Sipe 1 Yes 2 No Specify: Yes, Give Year or Dates:	Rican, etc.)	Specify:	ite, etc. Black
2 ho	15. Decedent's Education 16a. Decedent's Usuel Occupation		16b. Kind of Busines	s/Industry
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Daniel House	11 Horse Trainer		Self Empl	oyed
	17. Father's Name (First, Middle, Last) 18. Mother's Neme	(First, Middle,	Maiden Sumame)	
Mental H Mental H Inches off Inches of To Be	Guster Lee Hayes Vera	Lewis		
N DU N	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rura	I Route Numbe	er, City or Town, State	Zip Code)
10 mm	Florence M. Hayes - Wife 4603 56th Avenue, Blad	ensburg	. Maryland	20710
Hon Hon Hon	20a Method of Disposition 20b. Place of Disposition (Neme of	Date	20c. Location - City	
Pages ment if it ant if it	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other plece) Metropolitan Crematory 8/	/11/2000	Alexandr	ia, Virgini
S Paris	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	- D A		
88158	Gasch's Funeral Hom 4739 Baltimore Aven			MD 20781
	23a, Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac of			Approximate
Physician	shock, or heart tailure. List only one cause on each line.			Interval Between Onset and Death
Physician ////////////////////////////////////	Immediate Cause (Final			
Examiner	disease or condition resulting in death) a. Septic Suck			
- T	Due to (or es a consequence of):			
exacuted an and rial-transit Examiner	Biliary obstruction			
be executed ician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
2 2 2	cause. Enter Underlying Cause (Disease or injury c. Pancreatic Cancer			
ufficate be ng physicie es the bu	resulting in death) Last Due to (or as a consequence of):			
5 00				
The law requires that the death certained has been signed by the attending page 2 should be detached for use Completed by Physician/N				
the de shed	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did	tobacco uss contribu	te to the cause of de
Phy Oth		10	Y88 2 No 3	Probably 4 Unk
w requires that the been signed by the should be detached by the steed by Physical By Phys				
en s ould ould			an autopsy 24l	Were autopsy finding available prior to
lew re as be a 2 sh npie				completion of cause of death?
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certificate has rector, page 2 Be Comp	25. Wes case referred to medical 26. Place of Deetl			
ysician: is certific director, To Be	examiner? Hospital: Other:		dence 6 □Other (Si	anaiful
2 2 -	12 inpatient 2D Ervoutpatient 3D DOA 4D Nursing Ho		how injury occurred	эвспу)
leath. lor: After thi the funeral cation: 7	1 Natural 5 Pending (Month, Day Year) Injury Work?		,.,,	
Attending ir death. actor: After by the fune Ification	3 Suicide 6 Could not be	29f Loopting (Street and Number	Queel Pouto Number
or Allin by	4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	City or To	Street and Number or wn, Stete)	nurar noute Number,
O Series				
To the Hoptial or Attending P within 24 hours after death. To the Funeral Director. After completely filled in by the funeral Medical Certification:	29a. Cartifiler (Check only one) 1 ☐ Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, (Check only one) 1 ☐ Cartifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
Me of the	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
- s - o			nalos	1200
(2)	14.2354		08/09	6,000
0	M. Gebremichel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MESFIN GEBREMICHAEL 6130 Landover Road,	Chever	by MD 20	785
State	31. Date filed (Month, Day, Year) 82. Registrar's Signature			
Registrar	AUG 11 2000 person of sports			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** I:18AM Rosetta Cecelia Hawkins 2000 August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplaca (Steta or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2 KF Days Virginia 579-26-2945 79 Yrs. July 11, 1921 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10gl. Inside City Limits Prince George's Maryland Capitol Heights 1 No 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or items 23s or the Medical Examiner must be 5502 Walker Mill Road 20743 United States permit. Pages 1 and 2 should be filed within 72 hours efter death a Depertment of Heelth and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Hema 23, any injury or other treumstic event, the Medical Exercises mans Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th School Bus Driver Private 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Lucas Hiram Johnson Cecelia Moore 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5502 Walker Mill Rd., Capitol Heights, MD Lavon Ralph Hawkins - Son 20743 20b. Place of Disposition (Name of cematery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/15/2000 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. Cheltenham, MD 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. lugar. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical dden Corcliar Examiner Due to (or as a consequenca of) Examiner oronany physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the death certificete be Physician/Medical Due to (or es a consequenca ot): 98 USe signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sepsis by 24b. Were autopsy findings available prior to completion of cause of death? Endstage Menal directe 24a. Was an autopsy Completed certificate hes b lirector, page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only ona) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Umpatiant 2 ER/Outpatient 3 DOA 10 this funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 1 | Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident or Attendation of after deat 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in 24 hour. 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

20 Madical Examiner: On the basis of examination and/or investigation in my spinlar death accurate to the cause(s) and manner as stated. 29a Certifier Medical To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2000) 20054068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32 Ragistar's Signature

Herh

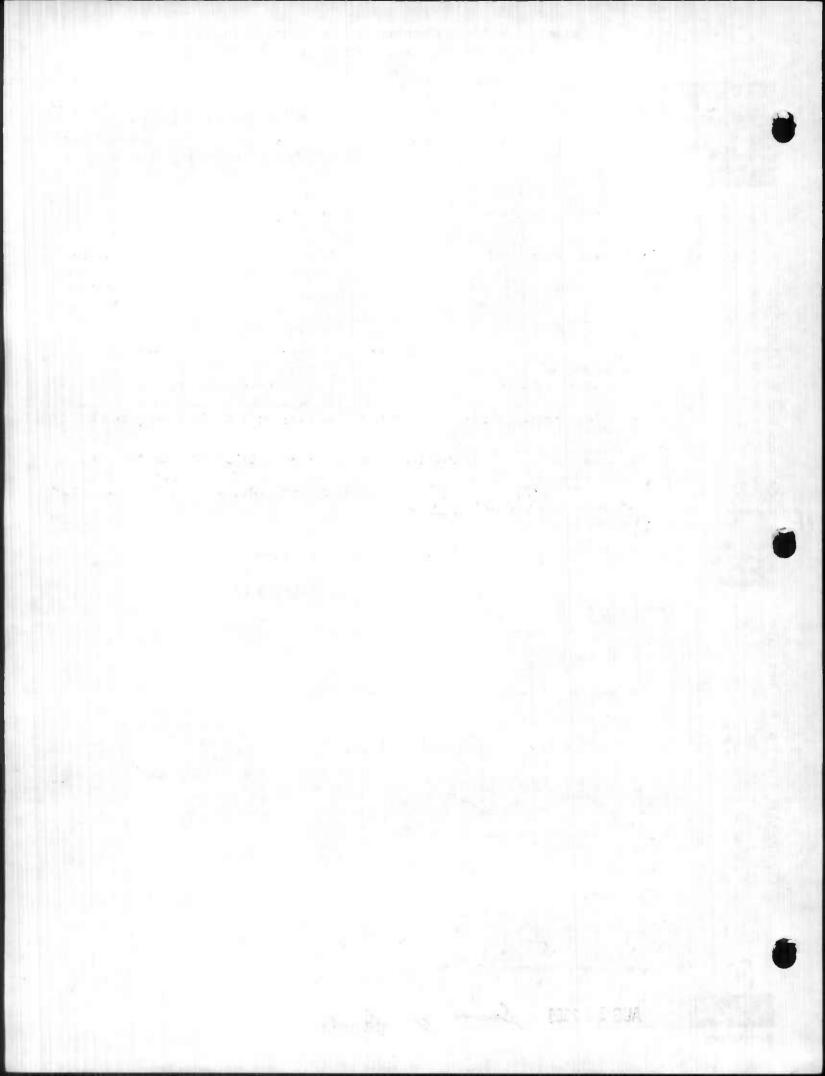
Paho George Hosp - Chevery - MU

Registrar

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31. Data filed (Month, Dey, Year)

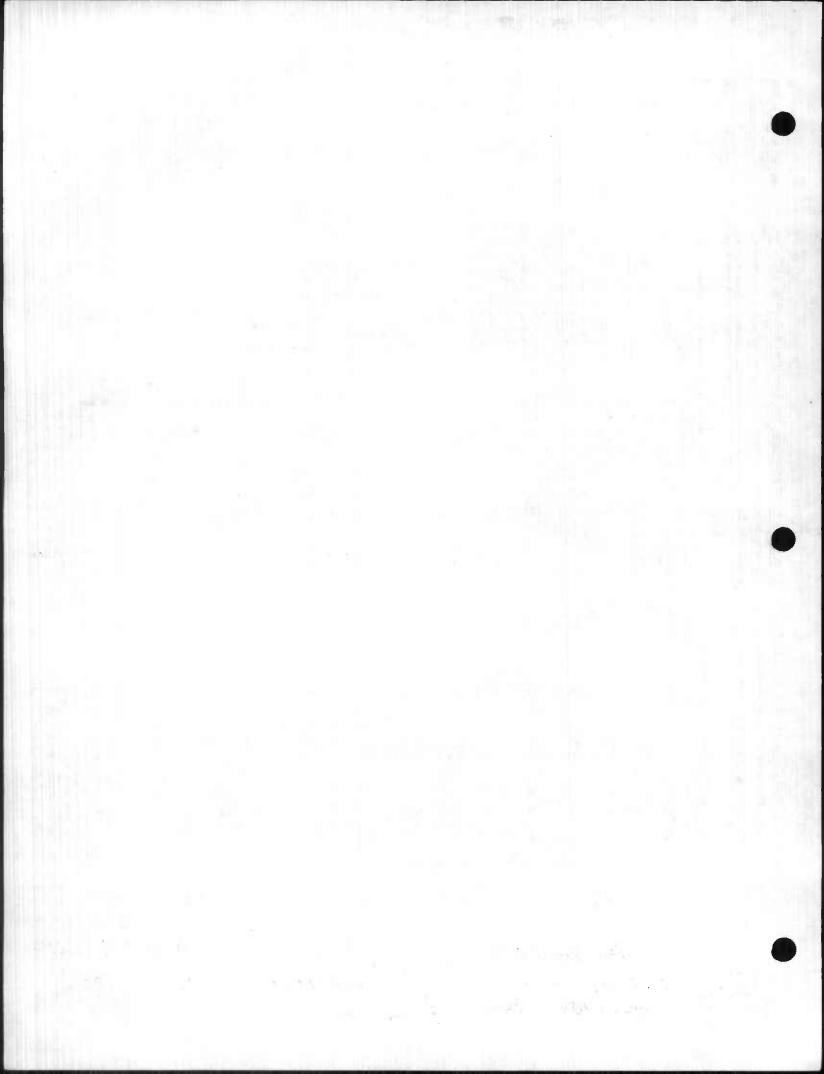


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 Carl Edward Hollins August 3:05PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1708 Brightseat Road, #103 Landover Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 13, 1950 9. Birthplace (State or Foreign Country) Wash., D.C. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 578-68-7252 50 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Landover Maryland Prince George's 1 Yes 2 No Director 28a-f 10e Street and Number 10f Zin Code 10g. Citizen of What Country? пвета 23а от 20785 United States 1708 Brightseat Road, #103 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black. Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yea 2 ☒ No Specify: Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) Private Porter - Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permi. Pages 1 and 2 should be fill.
Department of Health and Mental: Hy
important: If Item 27 is marked oth-any Injury or other treumetic event 88 Elizabeth Robinson Leon Hollins, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Leona Hollins - Wife 1708 Brightseat Rd., #103; Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2000 Lincoln Memorial Cem. Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 20019 4001 Benning Rd., N.E. Wash., D.C. Que an Enter the assesse, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 4 car disease or condition resulting in deeth) Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence ot): physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of) USB as signed by the a Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Was case reterred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menper of Death 28c. tnjury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Naturel 5 Panding 1 Yes 2 No death. Z Accident investigation 24 hours after deat Funeral Director: 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDORF 20603 ASHRAF MEELU

DHMH 16 Rev 6/95

Registrar

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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					Certificate d	of Death	7	Re	eg. No.	U	4014.	eath m Coraign DC Limits No Limits No MATH	
		1. Decedent's Name (First, Middla,	Last)					2. Date of Deat	h	Viii.	3. Time of Deat		
	Physician	Margaret Louise	Harpster					Month August	7. 20	Yaar 00	5:30 am		
	/Medical Examiner	4a Facility Name (If not institution, g				4b. City, To		cation of Death	4c. County				
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	Funeral			Age (In yrs. last birti			r 24 Hrs.	8. Date of Birth				aign	
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	r flows 230	11. Marital Status	12. Was Decede Armed Force	s?	13. Was Decedent If Yas, specify (of Hispanic O Cuban, Maxica	rigin? (Spe in, Puerto	ecify Yas or No- Rican, atc.)		e - Americk, White,	etc.		
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21215-002	n 72 hours after death with the Maryland "naturel", or items 23s or 28s-f show acrel Examiner must be notified at leted by Funeral Director	3XXVidowed 4 □ Divorced	Yaar or Data								White		
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Ma	2 2 2 2	William Thomas A											
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tin	Semit. Pag Separtment mportant: I iny injury o	4 Donation 5 Other (Special	-	Fort L	incoln Cen			/10/00 B	rentwoo	od, M	ע		
Bai	permit. Pag Department Important: I any injury o	21. Signature of Funeral Service Lic	ensee	0	Gasch's			e P A					
21		23a. Part 1. Enter the disease, or co	ce Has	ch	4739 Bal	timore	Aven	ue. Hyai	ttsvill	e. M	20781		
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ceus ly one cause on each	sed the daath. Do n n line.	ot enter the mode of	dying, such a	s cerdiac o	or respiratory arm	est,	1	interval petween		
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	15	resulting in death)		Due to (or as a c							1.0		
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	and Fran	Sequentially fist conditions,	- 1	Due to (or as a c		00 0	40 0		,		6.		
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or	the law require sate has been signed as page 2 should Completed	Permanen	t Cardu	àc Paceu	aker for SI	ck Sinu	5 5440	24e. Was a	med?	a\	ailable prior to		
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/ita	yecten: The law is certificate has director, page 2 To Be Comp	25. Was case referred to medicel examiner?				26. Plac	ce of Deat	h (Check only on	10)				
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Division of Vitai	ter the neral nera	27. Manner of Death 1 Natural 5 Pending	28a. Date of fr (Month, I	njury 28b. T	me of 28c.	Injury at Work?		28d. Describe ho	ow injury occur	red			
0	Artending or death. ector: After by the fune iffication	2 ☐ Accident investigat	ion			1 Yes 2	No						
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		29a. Certifier 1 Certifying I	Physician: To the be	st of my knowledge,	death occurred at th	e time, date a	nd place,	and due to the co	ause(s) and ma	anner as	stated.		
	ne Hosp in 24 hou he Fune pletely fil edical	one) 2 Medical Ex	aminer: On the basis and manner	stated.	or investigation, in r	ny opinion, de	etn occurr	ed at the time, o	ate end piece,	and due i	o tha cause(s)		
	To the com	29b. Signature and title of certifier	2010	2/ 11	29c. Lie	anse number			9d. Data signe				
	M	(VI	010	14	. B. I) 22	15%	+9 1	Augus	10	12001	0.	
	((30. Name and address of person wh	o completed cause o	f death (Item 23a) (Type, Print)								
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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Day Halbe

1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** John 5, 2000 August 12:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Hospice Home Baltimore
| H Under 24 Hrs. |
| Hours | Min. Baltimore If Under 1 Year 8. Dete of Birth (Month, Day, Year)
March 29 1931

9. Birthplace (State or Fore Country)
Pennsylvania 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Deys Months 69 Director 202-24-5773 Usual Residence of Decede 10a. Stale 10b. County 10c. City, Town or Location poemit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan peparament of Haalth and Mental Hyglens. Importants if Item 27 is marked other than "natural", or items 23s or 28s4 show eny injury or other treumstic event, the Medical Examiner must be notified at sonos. 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Directo Maryland | Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4907 Eastern Ave. U.S.A. 14. Race - American Indian, 20782 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unk. Bookbinder 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) å Frederick Halbe Margaret Mahoney 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Reba Wyatt (Daughter) 763 White Oak Dr. Bel Aire, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) 20c. Location - City or Town, State Data 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 8/8/00 Brentwood, MD 22. Name and Address of Fecility
Rendon/Hale Funeral Home 21. Signature of Princial Service Licen 9013 Annapolis Rd. Lanham, MD 20706 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest or heart leiture. List only one cause on each lina. Physician /Medical Immediate Cause (Final KSPIRATION PNEUMONIA 2 DKYS disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner Due to (or es a consequence ot) 3 MONTHS physician and the budei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? signed by t CANGE OF THE PROSTATE 1 Yaa 2 No 3 Probably 4 Unknown Records. à Completed 24a. Was an autopsy performed? 24b. Wara autopsy lindings evailable prior to CEREBRO-VISCULLE ACCIDENT completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 COther (Specify) | HOSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation Te the Hospital or Attending within 24 hours after deeth. To the Funeral Director: Atta 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 166.6,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

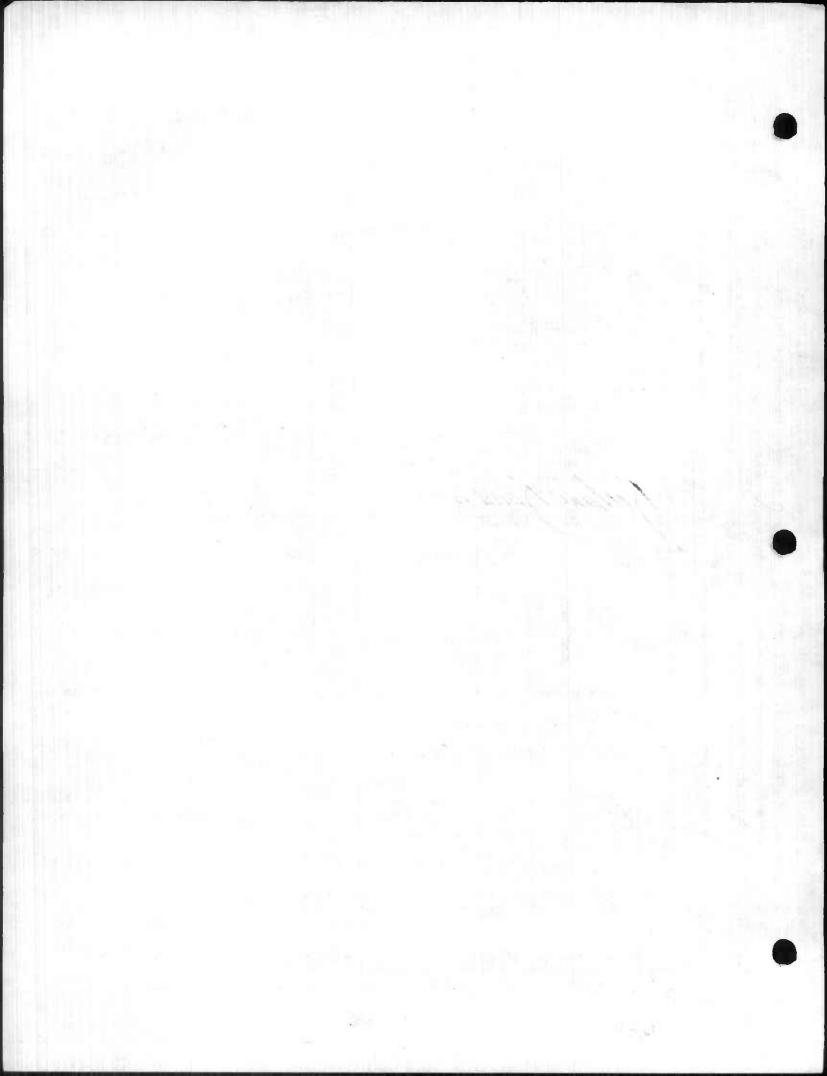
DHMH 16 Rev 6/95

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31. Date filed (Month, Day, Year)

O. ; 220 TUNBRIDGE POLP; BALTIMORE, MD. 212 12
32. Registrar's Signeture L.M. JUMAMOY. M.O.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			Certificate of	Death	Reg. I	No.					
	1. Decedent's Name (First, Middle, Last)			2	Dete of Death	Dev Year	3. Tima of Death				
Physician /Medical	Mild	lred Louise Hu	ighes		ugust 4,	2000	5:21AM				
Examiner	4a Facility Neme (If not institution, give	street end number)		4b. City, Town, or Loca	tion of Deeth	4c. County of Death					
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Funeral	5. Social Security Number 6. Set	7. Age (In yrs.	Yrs. Months Days	Hours Min.	Dete of Birth (Month, Dey, Yea Ct. 29,1	9. Births	place (State or Foreign				
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23a c	8805 Oxon Hill Ro	ad	20744		U	ISA					
		12. Was Decedent Ever In U Armed Forces?		Hispanic Orlgin? (Speci an, Mexican, Puerto Ric		14. Race - Americ Black, White,					
0 5	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2XXNo If Yes, Give	1 ☐ Yes 2XXNo			Specify: Whi					
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atic ev	Herbert Alexander			Ruth Ma	ttingly						
	19e. Informent's Name/Reletionship (Ty	rpe, Print)	19b. Meiling Address (Street	t end Number or Rurel F	Route Number, Cit	y or Town, State, Zij	p Code)				
44.14	Mary L. Hughes/Dau		Same as item	10							
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n A	4 Donalion 5 Other (Specify)	Re	surrection Ceme			inton, Md	•				
los in	21. Signature of Funbral Service License	9e //	George P.	Kalas Fune	ral Home	. P.A.					
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page 2 should			D	SEASE	24a. Wes en au performed	17 81	Vere autopsy findings vailable prior to ompletion of cause				
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Comp					1 ☐ Yes	2 No 1	☐ Yes 2☐ No				
director, page 2	25. Was case referred to medical examiner?	lospital:	Ot	26. Place of Death (
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for the formal f	1 Natural 5 Panding	28a. Date of Injury (Month, Day Year)		ry at 28 ork?] Yes 2 □ No	d. Describe now ii	ijury occurred					
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led in by the funeral Certification:	4 Homicide determined	28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Hurel Houte Number, City or Town, Stete)									
a fille	29a. Certifier 1 Certifying Phys	afcian: To the best of my kno	wledge, death occurred at the ti	ime, date and place, an	d due to the cause	e(s) end manner as	stated.				
To the Funeral Director: After the mipletely filled in by the funeral Medical Certification:			tion and/or Investigation, in my								
M	29b. Signeture and title of certifler		29c. Licen	se number	29d.	Date signed (Month,	, Dey, Year)				
,	· MC		2m D-	18545	ST AC	TOUGH	2005 1/2				
0/	30. Name and address of person who co	impleted cause of death (Item									
	P. WISBISICEP A	(N) 120	70 QU) UM	JE CENT	ER WA	HOORF, 1	Ud. 20602				
State	31. Dale filed (Month, Dey, Year)	32. Registrar's Signe									
Registrar	AUG 0 7 2000	General B.	porte								
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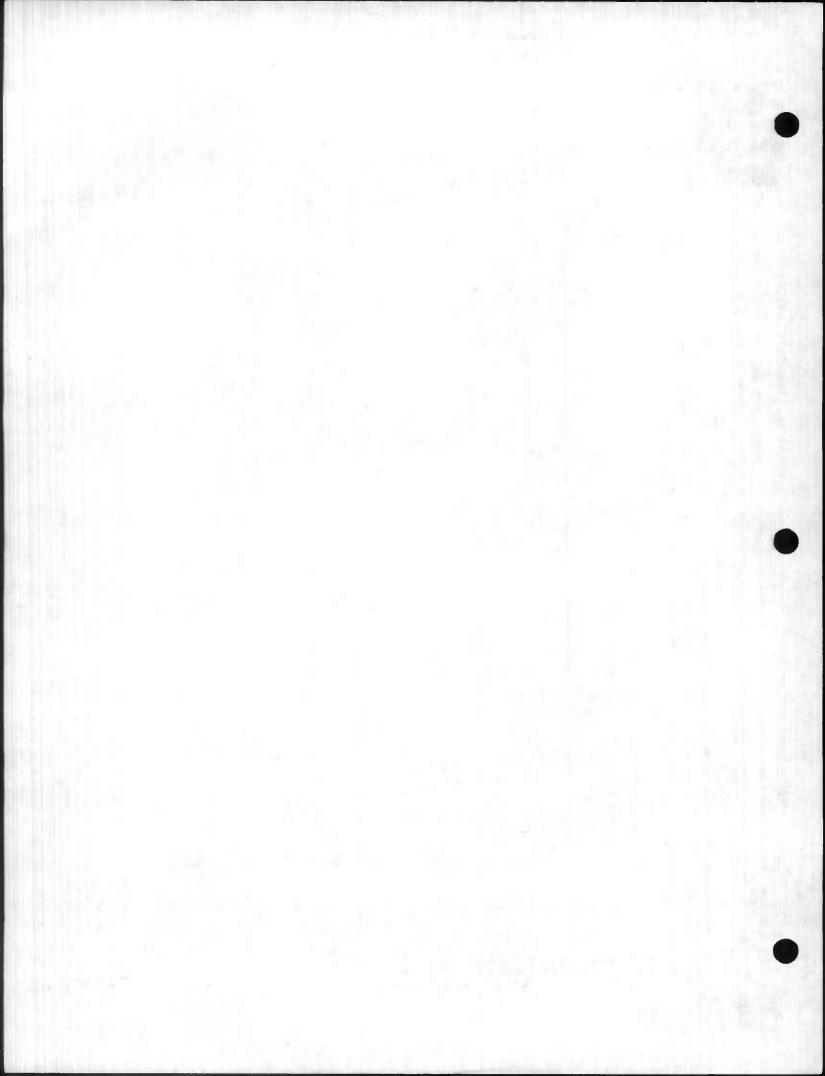
ORIGINAL

5:21 am

Hughes, Mildred

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 26752

	Certificate of Death Reg. No.											
	Decedent's Name (First, Middle, Last)						2	2. Date of Death 3. Time of Death				
Physician	James A. Hani	James A. Hankins					1	lugust	3	2000	13:33	
/Medical Examiner	4a Facility Name (If not institution, g	ve street and number)				4b. City, To		tion of Death	4c. County	of Death		
Examinici	SHADY GROVE	ADVENTIS	ST HOSP	ITAL		ROC	KVIL	LE	MON	TGOM	ERY	
Funeral			e (In yrs. last birtl	day) If Unde	r 1 Year	If Under	24 Hrs. R	Date of Birth		9. Birthp	lace (State or Fore	
Director	337-07-0263 Usual Residence of Decedent	120 M 20 F	91 Y	rs. Months	Days	Hours	Min.	Jan. 19	Year) 909	Ind	iana	
28a-f show northed at rector	10a. State 10b. County		10c. City, Town	or Location						10	Od. Inside City Lim	
o P	Maryland Montgo	M O Fr / I	Gaithe	shung							1 X Yes 2 □	
28a-f shownord at sector	10a. Street and Number	recy	ounne		p Code			1	Og. Citizen of V	What Coun	to/2	
23a or	333 Russell Avenue #523 20877-2833 USA									, mat 000m	,	
Hame Inserting	11. Marital Status	12. Was Decedent if Armed Forces?	Ever in U,S.	13. Was Dec	edent of I	Hispanic Orle	gin? (Speci	fy Yes or No- can, etc.)		e - America		
0 5	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No	1□ Yes						whi		
If item 27 is marked other than "natural", or other traumatic avant, the Medical Exact Other traumatic avant, the Medical Exact To Be Completed by	15. Decedent's E (Specify only highest g		16a. l	16a. Decedent's Usual Occupation (Give kind of work done duning most of work life. DO NOT use retired)			t of working		16b. Kind of B	usiness/Inc	Justry	
nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT	use retire	d)						
5		2		Sales	man				Insur	ance		
avant Be (17. Father's Name (First, Middle, Las	t)				18. Mothe	r's Name (First, Middle, M	Maiden Suman	10)		
arked affice To	William Taylor H	ankins				Lemm	a Mel	issa Ho	anikord	,		
E S	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addres	s (Street				City or Town,		Code)	
of other traumatic avant, the Mr. To Be Comp	Susan Swynford/D	quahter	10	860 Huy	ton	Stati	an Dd	Uionu	00 111	2210	7	
e do	20a. Method of Disposition	augirece	20b. Place of	Disposition (No.	ome of	2011	un nu	Date	1a, VA 20c. Location -	City or To	wn, State	
E 6	12 Burial 2 Cremation 3			n Cemet		(CO)	2/1	2/2000	20101101	~ ~ .	Indiana	
mportant: my injury ncs.			westo			one of Engitit		2/2004	enssee	aer,	Indiana	
any inje	22. Name and Address of Facility 4810 Wilson Blvd. Arlington, Va 22203 Murphy Funeral Home											
100	23a. Part 1. Enter the disease, or complications that days. Do not enter the mode of dying, such as cardiac or respiretory errest,								Approximete			
sician	Immediate Cause I mai disease or condition resulting in death									Onset and Death		
edical												
miner												
ē			Due to (or as a c	onsequence of):						5 days	
in and ia-transit Examiner		b. Myocaro								1	5 days	
Xa Xa	Sequentially list conditions, if any, leading to immediate		Due to (or as a consequence of):									
burie Burie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.								i			
ing physician and e as the burial-transit	that initiated events resulting in deeth) Last	E 201	Due to (or as a co	ensequence of	:					i		
use as												
for use										1		
bed /s	Part II. Other significant conditions	rt II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of			the cause of de	
ate has been signed by the attendi page 2 should be detached for use Completed by Physician/	Dieboto Hallet							1 Yes 2 No 3 Probably 4			bebly 4 Unkr	
S A	Diabetes Melliti	LS				_						
should should lefted	11							24a. Was a		24b. We	ere autopsy finding ailable prior to	
2 sh	Hypertension						_			mpletion of cause death?		
96								1 🗆 Ye	es 202 No	10	Yes 2 No	
a O	OF Man ages referred to medical	1				44 Pt	10 4			- 10	2169 24(10	
rector, page 2	25. Was case referred to medical examiner?	Hospital:			Ot	hor		Check only on				
al direction	1 Yes 2 No 27. Menner of Death	1 Inpatie			OA	4 LI NU			enca 6 Oth		у)	
funer funer flon	1 Naturai 5 ☐ Pending	(Month, De)		jury	28c. Inju			28d. Describe how injury occurred				
the cat	2 Accident investigation	he -		М		Yes 2					.=	
ed in by the funeral certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)						28	f. Location (SI City or Town	treet and Numl n, Stete)	ber or Rura	I Route Number,	
D D D												
Nedical Certification: To Be Com	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exs	hysicien: To the best of miner: On the basis of and manner sta	examination and	deeth occurre for investigation	d et the ti n, in my	me, date an opinion, dea	d plece, an th occurred	d due to the ca at the time, d	ause(s) and ma ate and plece,	anner as si and due to	tated. the cause(s)	
To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of certifier			2	ec. Licen	se number		2	9d. Date signe	d (Month,	Day, Year)	
- 8	1	1					-,					
4	Richard	taper	~		DY	47 4S	6		tugus	t 0	7, 200 FeeR M	
,	30. Name and address of person who							0	9		_	
	255 Rockville Pr	Ke, Suite.	IDIA, R	ockyil	le 1	MD 2	.0851	R	chard	SA	FeeR M	
State	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	, ,								
State Registrar	ALIGO 7 2	1	was L	. 60	all.							



State of Maryland / Department of Health and Mental Hygiene 26753 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Alice S. Herman 9, 2000 11:43 am August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4617 Wissahican Avenue Rockville If Undar 24 Hrs. Montgomery If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Days Hours Months 1 M 2 XF Yrs 100 Director 578-44-3329 July 27, 1900 Virginia Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or liems 23s or 28s-f ahor the Medical Examiner must be notified at 1 Yes 2 No Maryland | Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with I nent of Heelth and Mentel Hyglene.

Int: if Item 27 is marked other than "natural", or Items 23s or ity or other traumatic avent, the Wedgel Examine must be 4617 Wissahican Avenue Funeral 20853 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ĭ No Specify: If Yes, Give Year or Dates: Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Hair Care 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) 8 John M. Ballard Nora Belle Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patricia E. Douglas/ Daughter 4617 Wissahican Ave., Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 8/14/00 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. RACY STUVER. 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical . Congestive Heart Failure Examiner Due to (or as e consequence of) Examiner Coronary Artery Disease the deeth certificate be axecuted physicien and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): for use as 980 ned by the a 23b. Did tobacco use contribute to the causa of death? D.0 Part If. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Records. þ been si 24b. Wara autopsy tindings availabla prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 s has 1 Yas 2 No 1 Yas 2 No certificate Division of Vital I director. Be 25. Was case referred to medicat axaminer? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After 5 Pending investigation or Attending 1 BNatural death. 1 ☐ Yas 2 ☐ No Director: / 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d
To the Funeral Direct completely filled in by 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

To the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Sign itle of certifier D 08544 August 10, 2000 ss of mon who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

John J. Nerendino 31. Date filed (Month, Day, Year)

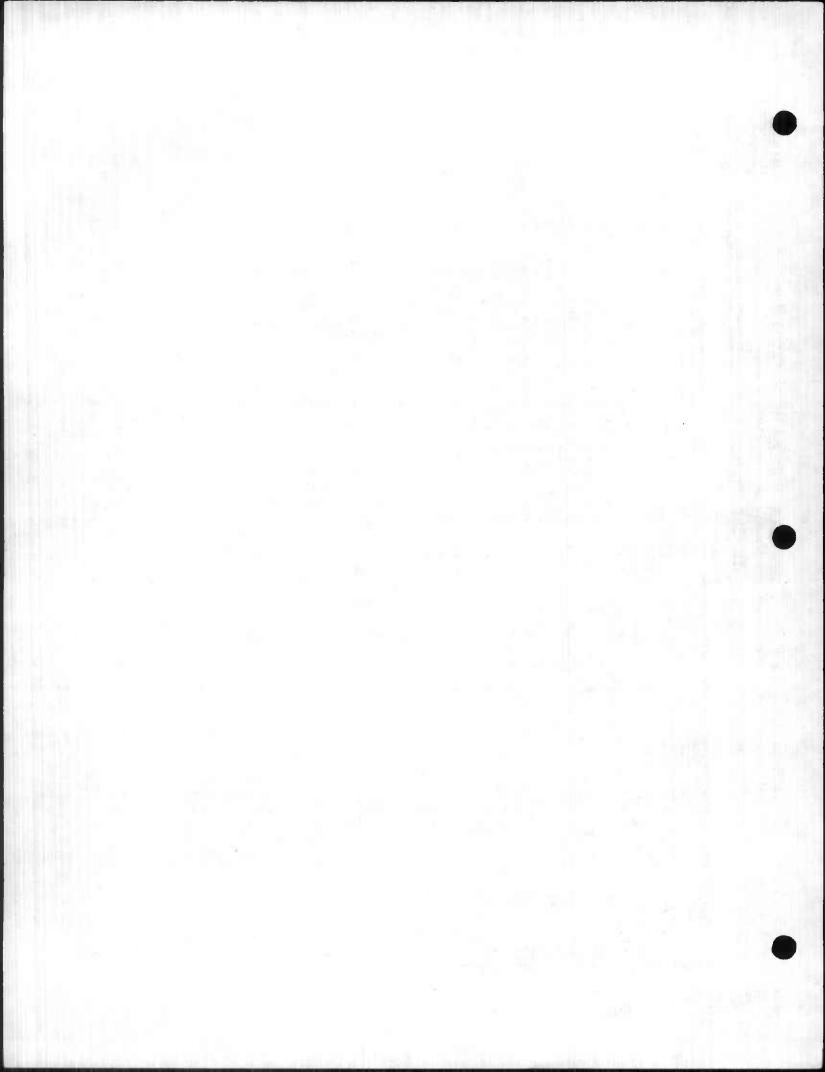
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2000

32. Registrar's Signature

4701 Randolph Road #216, Rockville, MD



State of Maryland / Department of Health and Mental Hygiene 26754 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month Physician KENNETH F. HERMSEN August 6, 2000 3:40 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 730 Beall Avenue Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 29, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 189 M 2□ F 391-30-5064 67 Yrs Wisconsin Director Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Manylar nest of Health and Mental Hyglene.
Int: If tam 27 is marked other then netural; or items 23a or 28a-f show any or other than the verify the Manylar or other transfer event, the Manylar or other transfer event, the Manylar or other transfer ovent, the Manylar or other transfer or not the Manylar or other transfer over the Manylar or other transfer or other transfer or other or other transfer or other tr Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Beall Avenue 20850 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1952–1956 1 ☐ Never Married 2 ☑ Merried 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor U.S. Government Baltimore, Maryland 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle Last) Martin Hermsen Marie Janssen 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 730 Beall Avenue, Rockville, Maryland 20850 Joan A. Hermsen/Wife 20b. Place of Disposition (Name of Aug. 9, 20a. Method of Disposition 20c. Location - City or Town, State tery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If eny injury or page. Gate of Heaven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Silver Spring, Maryland Robert A. Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licenses M00198 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Metastatic Lung Cancer l year Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) * 980 signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1⊠ Yes 2□ No 3 Probably 4 Unknown Records. þ 24b. Were autopsy lindings available prior to completion of cause of death? should l 24a. Was an eutopsy performed? Completed pege 2 s has 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No. Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No To 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending s after dec-1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours after Funeral Dire Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated Medical To the Hosp within 24 hox To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) Yar D21392 August 7, 2000 wara 3a) (Type, Print) 30. Name and address of person who completed cause of outh (thorn 809 Weirs Mill Road, Rockville, Maryland Patricia D. Kellogg, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

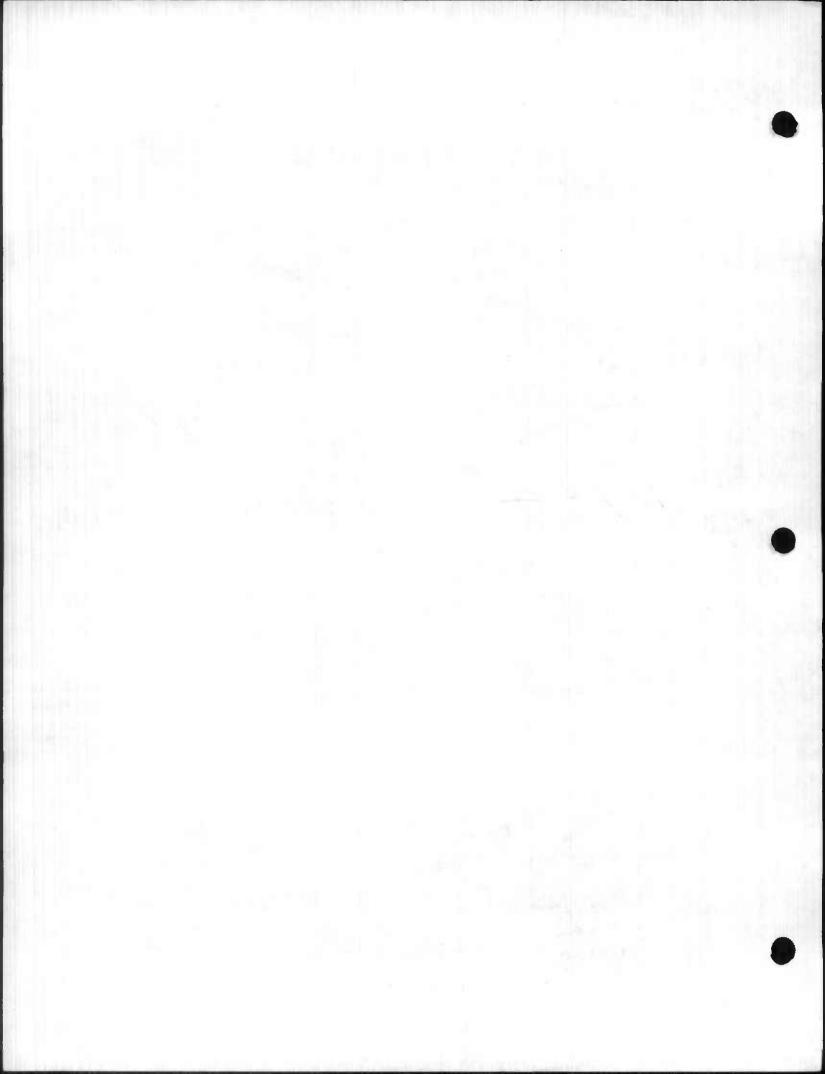
DHMH 16 Rev 6/95

Registrar

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	Amended It	em#5 perFHG787 9/12/2000	State of Maryland	d / Departmen		Mental Hy		26755
	Physician /Medical	1. Decedent's Name (First, Middle, Last) Jessie Ruff Jore	dan			2. Date of De. Month AVEUS	T 08 2	(aar 000 08:27 PM
	Examiner Funeral Director	4a Facility Name (If not institution, giva: Malcolm Grow Hosp 5. Social Security Number 217-20-8748 217-20-8748	ital	ast birthday) If Under Months		ing, MD	Prince	Georges Birthplace (State or Foreign Country) innsboro, SC
	show d.m.	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	10c. City	, Town or Location trict Heigh	nts	iay),	1)23 M	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	her death with the Mi Herra 23a or 28e-1, Inter must be notifie Funeral Directo	10e. Street and Number 5521 Stoney Meadow	Drive	10f. Zip	Code)747		10g. Citizen of Wh United St	tates
020	by B	11. Marital Statua 1 □ Nevar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas:	S. 13. Was Deced If Yas, spec	lent of HispanIc Origin? (sify Cuban, Mexicen, Puer 2012) No Specify:	Specify Yes or No to Ricen, etc.)	Black,	Americen Indian, White, etc. Black
1215-0	ad within 72 ho yglene, we then "naturn t, the Medical J Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		rk done during most of wa se retired)	orking	16b. KInd of Busi Private	ness/Industry
Maryland 21215-0020	in be filed w lental Hygie ked other to to event, the	10 17. Fether's Name (First, Middle, Last) John Douglas Hall		Social Wor	18. Mother's Na	me (First, Middle, uff Hall	Maiden Sumame)	
	and 2 show eaith and M n 27 is mer her traumet	19a. Informant's Name/Relationship (Ty. Marie Craig/ Daugh	ter	5521 Stone	_	ive, Dis	trict He	ights, MD 20747
altimore	t. Pages 1 tment of H nant if Ner slury or oth	20a. Method of Disposition 1 Burial 2 Tremation 3 R 4 Donation 5 Other (Specify)	emoval from State Che	lace of Disposition (Naremetery, crematory or of sapeake Cre	ematory			le, MD 20705
Ba	Physician /Medical	21. Signature of Finaral Service License 23a. Part1. Enter the disease, or complishock, or heart/allure. List only or	cations that ceused the death re cause on each line.	5538 1	d Address of Facility Funeral Home Marlboro Pik e of dying, such as cerdia	e, Fores	rrest,	Approximate Interval Between Onset and Death
	Examiner	disease or condition resulting In death)		r as a consequence of):	TE CAPACIT	3403 Com		
x 68760,	death certificate be executed attending physician end of for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last		r as a consequence of): as a consequence of):				
, P.O. Box	at the death do by the atternation for Physicia	Part II. Other algnificant conditions con	me 11. tus		euse given In Part I.		/	ribute to the cause of death? B Probably 4 Unknown
Records,	5 2 G						an autopsy omed?	24b. Were autopsy findings available prior to completion of cause of death?
ital R	ystclen: The is s certificate he director, page To Be Corn	25. Was cese referred to medical examiner?			26. Place of De	ath (Check only o		1 Yes 2 No
Division of Vital	T digital	1 Yes 2 No Part 1 Yes 2 No Part 1 No Part 2 No	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DC 28b. Time of Injury M	OA Other: 4 Nursing 8c. Injury at Work? 1 Yes 2 No		dence 6 Other	
Divis	her different in by	3 Suicide 6 Could not be 4 Hornicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor	r, office	28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	(Check only 2 Medical Examir one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or investigation	in my opinion, death occ		date and place, an	nd due to the cause(s)
D	5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 ×	29b. Signatura and title of certifier	20 m	Du	D3955	>	~	(Month, Day, Year)
	(3)	30. Name and address of person who co George C- Haj 31. Date filed (Month, Day, Year)	mpleted cause of death (Item	0. 4850	Forbes Bl	ud Lan	hom, m	4 20706
	State Registrar	AUG 1 1 2000	32. Registrar's Signal	G. Span	6			

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State of Maryland / Department of Health and Mental Hygiene 26756 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** William Steven Jones, Jr. 9, August 2000 12:20 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12514 Kensington Lane Bowie Prince Georges If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1₩ M 2□ F Days Months Hours 12 216-27-1844 Aug. Director 23,1987 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits than "natural", or hame 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Md. Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12514 Kensington Lane 20715 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 20 No If Yas, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Education Student permit. Pages 1 and 2 should be list. Department of Health and Mental Hy important: If Item 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be William Steven Jones, Sr. Marianne Marks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) William S. Jones, Sr. father 2311 Dartmouth Ln., Crofton, Md. 21114 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 Sp Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 08-11-00 Brentwood, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Beall Funeral Home Robert G. M00025 Beall 6512 N.W. Crain Hwy., Bowie, 20715 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. Approximata Intarval Batween Onset and Deeth Physician Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Diva to (or as a consequence of). Examiner the buriel-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last and Due to (or es a consequence of): attending physician Box 68760. certificate be edical Due to (or es e consequence of): USO ES ! Physician/M Division of Vital Records, P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy parformed? Completed peed 188 2 No 1 Yas 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 80 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this funeral 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? edical Certification: After s after deeth.
It Director: After
ad in by the funer 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

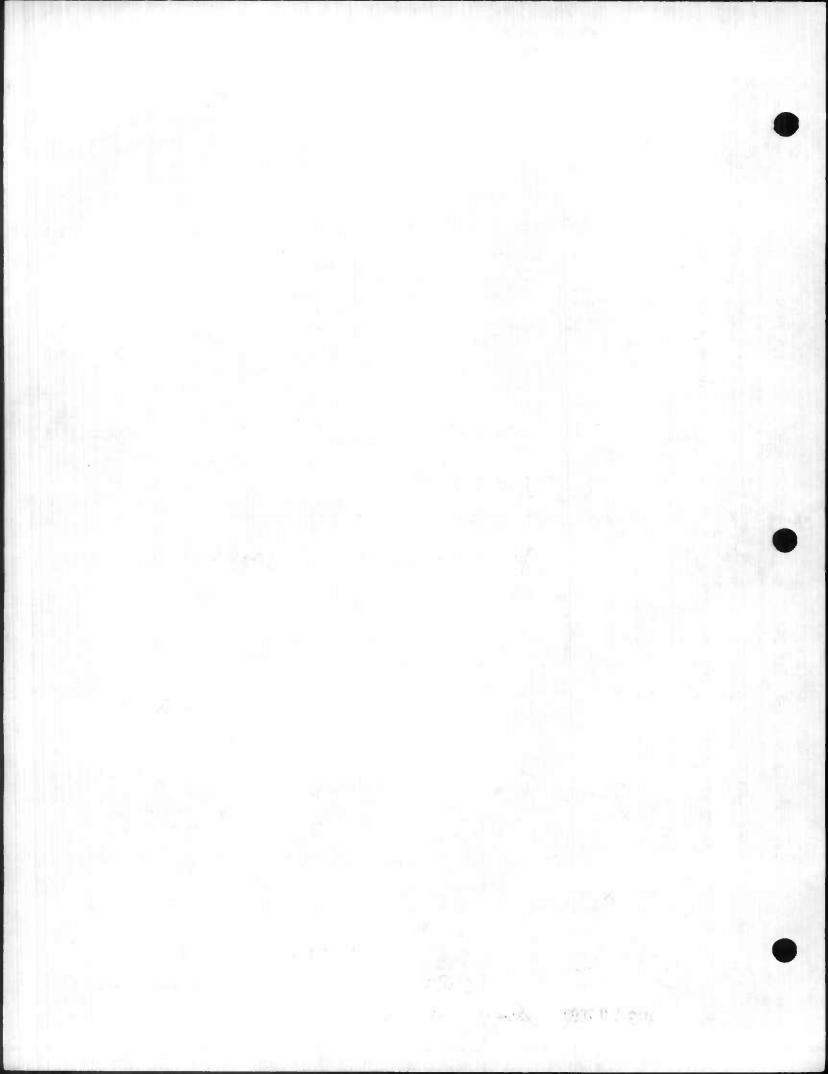
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifier npletely (Check only one) 29b. Signature and title of 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chigan Ave Wush D RICI 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

State

Registrar

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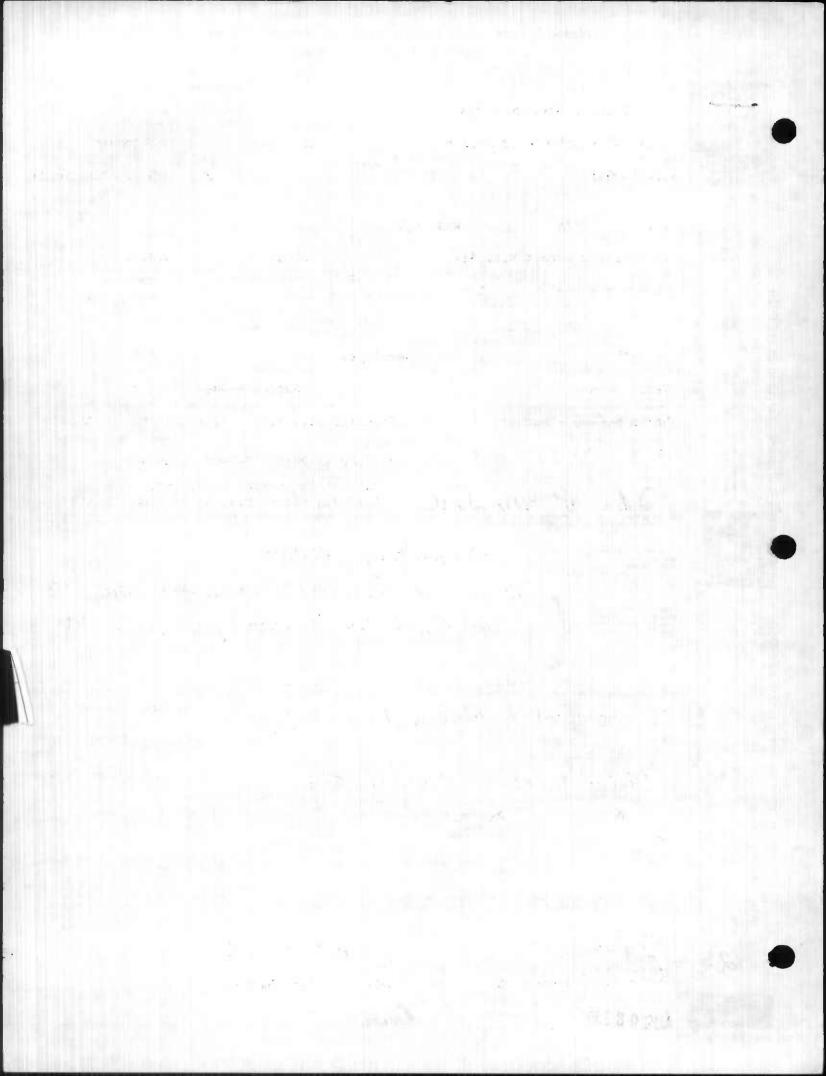


State of Maryland / Department of Health and Mental Hygiene 00 26757

			Certi	ificate of Death		Reg. No.	60101
	4.4.5	Decedent'e Neme (First, Middle, Last)	24,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-		2. Date of Dea	ith Dev Yee	3. Time of Death
	Physician /Medical	BRUNELLE C. JOHNSON			August	6, 2000	7:17 PM
	Examiner	4e Facility Name (If not institution, give street and number)		4b. City, Town	n, or Location of Death	4c. County of De	ath
131		Washington Adventist Hospit		Takoma		Montgome	ry
	Funeral Director	5. Social Security Number 251-38-0488 Usual Residence of Decedent		ff Under 1 Year If Under 24 Months Deys Hours	Min. 8. Dete of Birt (Month, De)	9. B (1931 Sou	dirthpleca (State or Foreign Country) 1th Carolina
	A H		10c. City, Town or Loca	ition			10d. Inside City Limits
	or 28s-fah	D.C. N/A	Washington	1 10f. Zip Code		10g. Citizen of What 0	1 ∑ Yes 2 □ No
	ocean with the maryland ma 23s or 28s-f show man be nothing at	1675 Primrose Road N. W.		20012		U.S.A.	
	alt, or its	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Evarmed Forces? 1 Yes, Give Year or Dates;		es Decedent of Hispenic Original fest, specify Cuban, Mexican, 기업 Yes 2反 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Specify:	
5-0	ygiena. Ne than "natural", It, the Medical	15. Decedent's Education (Specify only highest grade completed)	(Give kir	nt's Usuel Occupation nd of work done during most o	of working	16b. Kind of Busines	s/Industry
2121	- 4 30	Elementary/Secondary (0-12) College (1-4or 5+)	life. DC	ONOT use retired)			
12	Hygiena. Other than ent, or	12th	Nurse	40 Marked	s Neme (First, Middle,	Private I	outy
and	S S S S S S S S S S S S S S S S S S S	17. Father's Neme (First, Middle, Last)				Maiden Sumeme)	
Z Z	should be filled within and Mental Hygiena. I marked other than umatic event, the III To Be Comp	Marcelleus Dawkins	405 44-11		Gilliam	Chara Tana Chara	Tin Codes
2	5 - B - B - B	John A. Smith - Nephew	1675 P	Address (Street end Number Primrose Road		ngton DC 2	20012
w .	0 0	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stete		itory or other plece)	Dete	20c. Location - City	
Itim	Department Department Important: if any injury o	4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee	Rock Creek			Washingtor	1 D.C.
Ва	Departm Departm Importu any inje	21. Signature of Funeral Service Licensee P Y Mana L		Nome and Address of Facility Marshall's Fun 4217 9th Stree			20011
	11 11	23e. Part Atther the disease, or complications that caused it					Approximete Interval Between
100	hysician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in deeth)	pticem que to (or es e conseque	inca of):			Onset and Deeth
3	is a	o Subali	00	terial end	tocarch	tis.	
0,	g physician and as the burial-transit	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury	ue to (or es e conseque	enca of):	locar ch		
68760,	physicle is the bu		ue to (or es e conseque	mac so	CEU		
99 X		d.					
Вох	atten	•			001 011		
P.0	d by the etache	Pert II. Other significant conditions contributing to death but Ful Stale rend	not resulting in the und	enying cause given in Pert I.			uta to the cause of death? Probably 4反Unknown
ords	been s should	Throm socytopenia, A	Erypheral	Vascular d		en eutopsy med?	b. Were autopsy findings available prior to completion of cause of death?
= 6	certificate has be rector, page 2 s	Alsdominal wound	infection	on, Belateral	11-17	∕es 2√No	1 ☐ Yes 2 ☐ No
of Vitai	is certific director,	25. Was case referred to medicat examiner? Hospitel: Hospitel:	-7	Othor	of Death (Check only o		
0		1 Da inpatient		3LI DOA 4LI NUR	ing Home 5 Resident	denca 6 LIOther (S) now injury occurred	becity)
uo F	After fune	27. Manner of Death 1 Naturat 5 Pending (Month, Day) 2 Accident investigation	Year) Injury	28c. tnjury at Work? M 1 Yes 2 N		,,	
	Attending residence of a block of the funeral led in by the funeral Certification:	3 Suicide 6 Could not be	y - At home, farm, stree (Specify)	et, factory, office	28f. Location (S City or Tox		Rural Route Number,
	within 24 hours after dealt. To the Funeral Director: completely filled in by the Medical Certifical	29e. Certifier (Check only one) 1 Certifying Physician: To the best of the basts of earth one) 2 Medical Examiner: On the basts of earth one eart	xamination and/or inves				
- 6	vithin complete	29b. Signeture and title of contract		29c. License number		29d. Date signed (Mo	onth, Day, Year)
		17/ M	D	D 5/083	200	08-08	
	(5)	30. Name and eddress of pulson was completed cause of deal 12 A . S . WSWF M	ith (Item 23a) (Type, Pr	rint) VULAGO Pan	-K Drive	Green	selt M) 20770
	State	31. Date filed (Month, Day, Year) AUG 0 9 2000 32. Registrer	s Signeture	1		, , , ,	
	Registrar	AUG V 3 ZUUU	(D)	spark!			

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State of Maryland	/ Department of	Health and	Mental Hygiene

Amended Item	n#18,19a perINFG787 9/1	State of N	Maryland		artment o				giene Reg. No.	0 2	26758
	1. Decedent's Name (First, Middle, La							2. Date of Dea	ith		3. Time of Death
Physician	Shannon Sh	atera Jon	188					Month August	Day 2	Year 2000	3:27pm
/Medical Examiner	4e Fecility Name (If not institution, giv				-	4b. City, T	own, or Lo	cation of Death			3.2.7
CAGIIIII	National Institu	ite of He	alth			Beth	esda		Montg	omer	v
Funeral	5. Sociel Security Number 6. S	Sex 7. A	Age (In yrs. les	st birthdey)	If Under 1 You Months Da	ear If Unde	r 24 Hrs. Min.	8. Date of Birth (Month, De)			lace (Stete or Foreign try)
Director	577-04-9041 Usuel Residence of Decedent	□M 2 X) F	21	O Yrs.	Months Da	lys Hours	Willi,	Feb 27			ington DC
M was	10a. State 10b. County		10c. City,	Town or Lo	ocation					10	0d. Inside City Limits
28a-f sho notified at	D.C. N/A		Wash	ingto	n						Yes 2□No
or 25a-f a be notified Director	10e. Street and Number				10f. Zip Cod	le			10g. Citizen of V	Vhat Coun	fry?
	117 Franklin Str	eet N.E.	#11			200	02		U.S.A		
har death viller reserved	11. Maritai Status	12. Was Deceder Armed Forces		13.	Was Decedent if Yes, specify (of Hispanic O Cuban, Mexica	nigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)	14. Rac Bied	e - America k, White, o	
y F.	1 Never Married 2 Married	1 ☐ Yes 2X If Yes, Give			1 ☐ Yes 2√□	No Specify	<i>r</i> :		Specify	Bla	ck
DOOZ DOOZ DOOZ DOOZ DOOZ DOOZ DOOZ DOOZ	3 Widowed 4 Divorced	Year or Dates		40. D.	de elle Harret Or						
od within 72 hours at Syljonin 12 hours at Syljonin 12 hours at 14 the Madical Exam Completed by 8	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usuei Od kind of work do DO NOT use re	one during mo	st of worki	ng	16b. Kind of Bu	isiness/ind	Justry
112	Elementary/Secondary (0-12)	College (1-4o	or 5+)			un ou)			NT / A		
	17. Fether's Name (First, Middle, Last)		onen	ployed	18. Moth	ner's Name	(First, Middle,	Meiden Suman		
Maryland 6 2 should be fine th and Mental Hy 7 is marked oth traumatic event To Be (Terry Jones					Sh	aron	McChee	McGee		
THE PERSON IN	19a. Informant's Name/ ionship (Type, Print)		19b. Maii	ng Address (St				or, City or Town,	State, Zip	Code)
Ma md 2 am ar frau	Sharon MeShee - 1								shingto		
	20a. Method of Disposition		20b. Pia	ce of Disp	osition (Neme o	f nlace)		Dete	20c. Location -	City or To	wn, Stete
More Pages 1.1 sent of Hs rut. If Rem ry or oth	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		10		Memori		k 8	8-8-00	Landove	r MD	
alti	21. Signeture of Funeral Service Licer		110		2. Name and Ad Marsha					1 110	
M South	101- P	Im	1 10							D.O. (00011
	23a. P rt Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the deeth.	Do not en	ter the mode of	dying, such a	s cerdiac o	r respiretory er	shingtor	1 DC .	Approximete
Physician	shock, or heart failure. List only	one cause on each	ine.								Onset and Death
/Medical	Immediate Cause (Final disease or condition	+	PRENI	cot	cy.	faile	110				
Examiner	resulting in death)		Due to (or a	es e conse	querce of):						
je je		Propi	10,561	10.	MAULT	Foral	100	Kenro.	phalos	other	Couks
executed in and industriansit	Sequentially list conditions,	b	Due to (or a	as a conse	quence of):			. 01100	1	1	4 . 4 .
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. Ur	ndefil	ned	CD	-47	cell	19m	chaper	lia	life)ong
S s s	that initiated events resulting in deeth) Lesf	C.	Due to (or a	s a conse	quence of):			1			0
x 68 entifica ling phr e as th		d									
BO)		u.									
p.O. Box 68 the death certifica by the attending phrached for use as the	Part II. Other eignificant conditions of								lobacco use co	ntribute to	the cause of death?
Ph hat th	Dissemina	ted 1	Nuca	hace	Lecium	, AU	ium	10	Yes 2 No	3 Prol	bably 4 ☐ Unknown
dS, ires to signed be debe			1	1000	terium	I	infr	O Ode Wee	an autopsy	24h W	ere autonsy findings
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the ertification: To Be Completed by Physician/Med							11/2	perfo	med?	CO	ere autopsy findings allable prior to mpletion of ceuse
Red has law	11			/	/ .			A.	-/		deeth?
Coole	Mucocuta	neous	CC	una	idias	15		101	Yes 2 No	10	Yes 2
Vita iclan iclan sector	25. Was cese referred to medical exeminer?	Hospital:				Other:		n (Check only o			
Physical distriction	1 ☐ Yes 2 No 27. Manner of Death	npa	atient 2 E	R/Outpatie		401	-		dence 6 Oth		(v)
Ing I	1. Naturai 5 □ Pending	28a. Date of in (Month, L	Dey Year)	Injury	M 200.	injury at Work? 1 ☐ Yes 2 [200. Describe i	iow aljuly occur	100	
isicati the death	2 Accident Investigatio 3 Suicide 6 Could not b	e con Dines of I	Injune At hom	o form of	reet, factory, of			28f Location //	Street and Numi	her or Rure	al Route Number,
or A patient or A in by in by	4 Homicide determined	building.	etc. (Specify)	ie, iariii, si	reet, lactory, on	lice		City or To		or ridic	or ricoto realizar,
Pital Filled	29a. Certifier 12 Certifying Ph	veiden: To the hor	et of my knowl	adaa daal	h coursed at th	o timo, doto s	and place	and due to the	naucole) and m	20001 20 6	toted
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Med	(Check only 2 Medical Exar	ysician: To the bes ninar: On the basis and manner	of examination stated.	n and/or in	vestigation, in r	ny opinion, de	eath occurr	ed et the time,	date and place,	and due to	the cause(s)
Vithin To the	29b. Signature and title of certifier				29c. Lie	cense number			29d. Date signe	d (Month,	Day, Year)
6	1XLL				0	00 54	157	-3	08-0	3-0	00
(d)	30. Name and address of person who	completed ceuse of	f death (Item 2	23a) (Type							
	Janaki Kuru					Pike.	Beth	nesda, l	Md 20892	2	
State	31. Date filed (Month, Dey, Year)		strar's Signatu					,			
		/			chal						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JOHN PETER JOYNT II **AUGUST** 12, 2000 12:30 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 10 M 20 F 192-14-7281 73 Director DECEMBER 24,1926 FLORIDA Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 Yes 2√ No MARYLAND CHARLES WAI DORF Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 the Medical Examiner must be. 3105 EUTAW FOREST DRIVE Berne 23a 20603 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 10 Yes 2 No
If Yes, Give
Year or Dates: 1945-1946 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Merital Status Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 8 Baltimore, Maryland 21215-0020 1□ Yes 2√□ No Specify Specify: WHITE Py Py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) G.S.A. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if Nem 27 is marked other th, any injury or other traumatic event, the 2008. DIRECTOR OF PERSONNEL U.S. FEDERAL GOVERNMENT 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) 88 JOHN P. JOYNT LULU B. SAUCER 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 441065, FT. WASHINGTON, MD JOHN P. JOYNT, III/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriai 2 Cremetion 3 Removet from Stete RESURRECTION CEMETERY 08-18-2000 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fatheral Bell 150 Godhane 22. Name and Address of Fecility
THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX JPK KNISLEY WALDORF, MARYLAND 20604-0156 JOHN P. M01164 156, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximeta Intervel Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting In death) /Medical ATHEROSCHLEROTIC HEART DISEASE YRS Examiner Due to (or as a consequence of): Examiner burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): physician s the burial Box 68760. Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of) 980 P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? DEMENTIA certificate DECUBITUS ULCER 1 Yes 2 □ No 1 ☐ Yes 2 No 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: afor Attending F after death. Affer 5 Pending investigation 1 M Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) JayouV. D-0050883 AUGUST 14, 2000

State Registrar 25500 POINT LOOKOUT ROAD, LEONARDTOWN, MARYLAND 20650

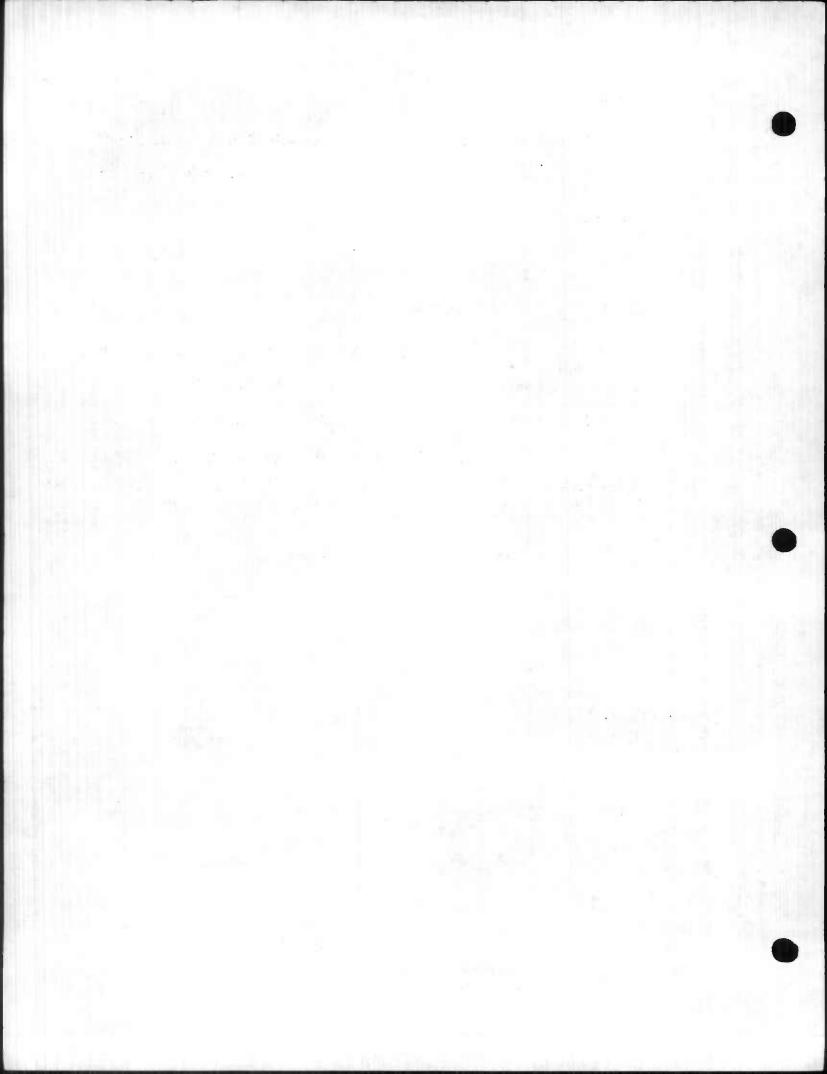
30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

AUG 1 5 2000 >

32. Registra/s Signeture

YAHIA M. TAGOURI, MD.,

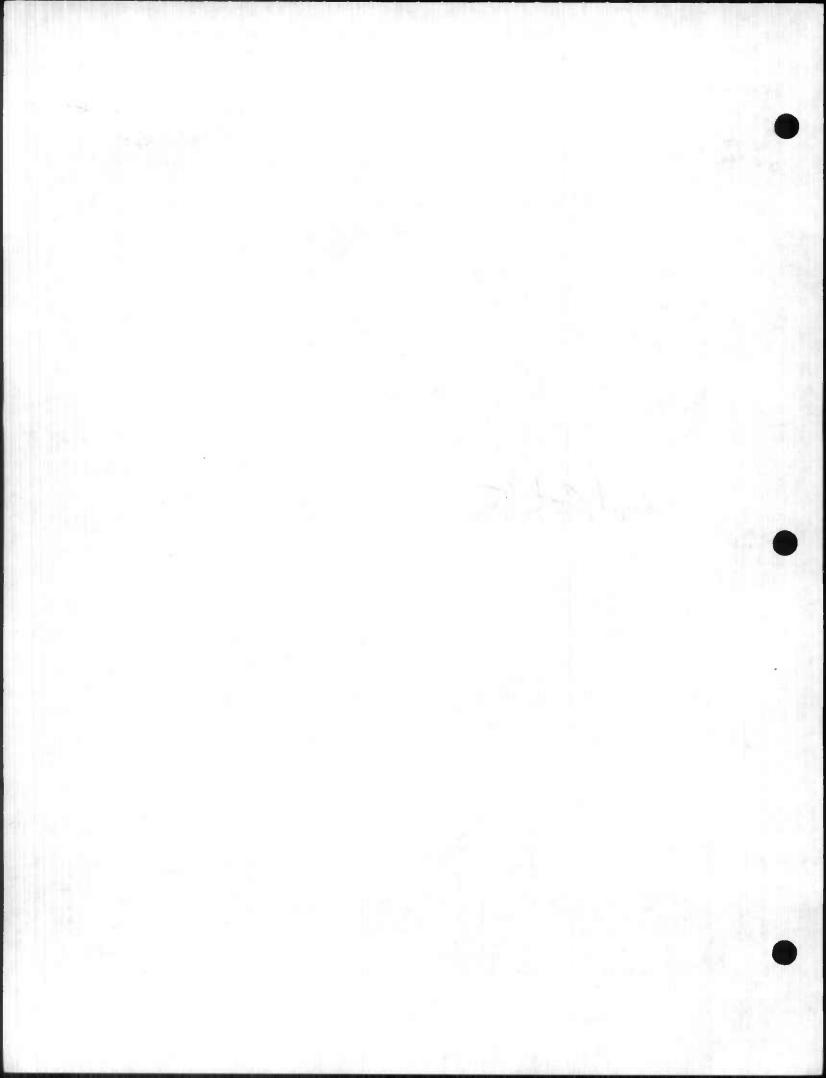
31. Dete filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

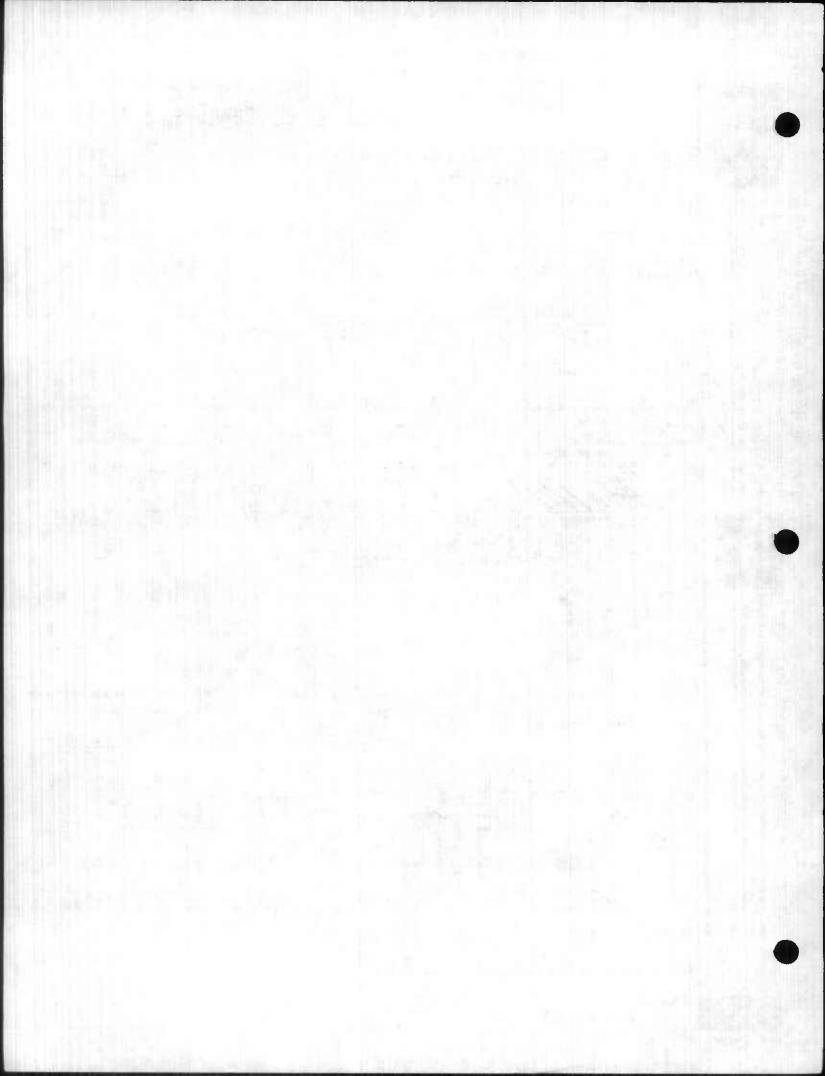
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			Cei	rtificate	of D	eath		Reg	g. No.	2	-0700
	1. Decedent's Neme (First, Middle, Las	t)	4 10	0.10				Date of Death Month	Dey	Yeer	3. Tima of Death
Physician [®] /Medical	Joan Stonestre	et Jameson						ugust		000	08:10A
Examiner	4a Facility Neme (If not institution, give 5230 Bryantown	Charles and Carlotte			4b.		n, or Locatio		4c. County of		
Funeral Director	5. Social Security Number 6. S 214-32-9906	7. Aga (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Undar 24 Hours	Min. 8.1	Data of Birth Month, Dey, r. 19,	Year) 1933 H	9. Birthple Count Lughs	ace (State or Foreity) Ville, Mo
syland Int	Usuel Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10	d. Inside City Limi
her death with the Maryla flarms 23s or 28s-f show fine must be notified at Furneral Director	Maryland Charles 10e. Street and Number	Br	yantown	10f. Zip C	Code			10	g. Citizen of W	hat Count	1 ☐ Yes 2623 N ry?
ach with	5230 Bryantown Ro			2061					U.S.A.		
by by	11. Merital Stetus 1 Nevar Marriad Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Datas:		Was Decede If Yes, specif 1 ☐ Yas 2			n? (Specify Puerto Rica White	Yas or No- n, etc.)		White, e	tc.
natur dicai	15. Decedent's Ed (Specify only highast gre		16a. Dece	dent's Usuel kind of work DO NOT use	Occupation du	ion ning most o	of working	1	6b. Kind of Bus	iness/Ind	ustry
ad within 72 ho ygiene. wer than "nature t, the Medical.	Elementery/Secondery (0-12)	College (1-4or 5+)		sewife	retired)			1	Housewi	fe	
to Be C	17. Father's Neme (First, Middle, Last) Francis Stonestre	et			1			rs, Middle, M dsmith	aiden Sumema)	
2 should and N and N is man	19e. informent's Neme/Reletionship (7	ype, Print)	19b. Meilin	ng Address ((Street an	d Number	or Rurel Ro	oute Number,	City or Town, S	Steta, Zip	Code)
of Health of Health I llem 27 r other tr	Joseph Warren Jame 20e. Method of Disposition 1色Buriel 2 □ Cremetion 3 □	20b.	5230 Place of Disponentery, cremetery, cremetery	Bryant sition (Neme metory or oth	e of				Md 20 Oc. Location - C		wn, Stete
fment fant: It	4 ☐ Donetion 5 ☐ Other (Specify	St	.Mary's				08-	16-00B	ryantow	n, M.	aryland
Depa Impo any is	21. Signeture of Funerel Service Licen	1 (1 M006	1	Name and			ls Fun	eral H	lome P.A	1.	MD 2062
Physician /Medical Examiner	23a. Part. Enter the disease, or compared to the compared to the control of the c	. Peritonea		ncer w							tritèrvel Between Onsel end Death
nding physician and use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last	c	or es e consec								
death ce de attendi ed for use siclan/	Pert II. Other eignificant conditions co	ontributing to death but not re-	sulting in the u	nderlying cau	use giver	in Pert I.		23b. Did tob	sacco use con	tribute to	the cause of dea
ed by the attendional detached for use								1 □ Ye	● 2□ No	3 Prob	ebly 4 Unkn
The law requires that the sale has been signed by the page 2 should be detached page 2 should by the completed by Phys			Ц					24a. Wes en perform		ava	re eutopsy tinding ileble prior to npletion of causa leath?
cate ha								1 ☐ Yas	×XX	1 🗆	Yes 2□ No
certific irector,	25. Wes case reterred to medical exeminer?	Hospitel: 1 Inpatient 2	150/0-4-4	- 2C DOA	Other			heck only one	nce 6 Othe	- (Canaik	
After this c funeral dire	27. Manner of Death ADMaturel 5 Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time o		lc. tnjury Work		28d.		w injury occurre		/
To the anospitus of Attenting Property of the Pure and Interctor: After the Completely filled in by the funer Medical Certification:	2 Accident Avastigation 3 Suicide 6 Could not be 4 Homicide determined		nome, ferm, str					Location (Str. City or Town,		er or Rura	Route Number,
in 24 hours in 24 hours he Funeral pletely filled edical Co	29a. Certifier (Check only one) 1 Certifying Physics 1 Medicat Example:	reiclan: To the best of my known iner: On the basis of examine and menner steted.	owledge, deetletion end/or in	h occurred et vestigation, l	t the time In my opi	, date end nion, deeth	plece, end occurred a	due to the ca t the time, da	use(s) and mar te end pleca, a	nner es st nd due to	ated. the cause(s)
within To the comple	29b. Signeture and title of certifier		0	29c.	License	number		29	d. Dete signed	(Month, I	Day, Year)
	* Karifi	M. Mall	tu	Dein/\	D28	352			Augus	st l	0, 2000
95 . "	30. Neme and address of person who of Krishan MAthur	MD., P.O.	Box	1703,	, La	Pla	ita,	MD 2	0646		-1-4
State	31. Deta filed (Month, Day, Year)	32. Registrats Sign	eture	4	loca	1					



				State	of Marylar				Death	and Me		Reg. No.	U	26	761
	Physician /Medical	1. Decedent's Nam Helen (na (First, Middle Gwendoly							A	Month	Day	Yaar	3. Time 7:5	2 pm
	Examiner	4a Facility Name		The second	umber)			4			tion d Deeth				/
			Hospit		7 Ann //n	lant histheless	al If Unde	er 1 Year	Lanh		Date of Bird	Princ		0	
	Funeral Director	5. Social Security 577-62-1	1210	6. Sex 1 M 2 F	7. Age (In yrs. 53		Months		Hours	Min	Date of Birt (Month, Date larch I	v. Year)	Wash:	ingto	on, DC
	P	Usual Residence of	10b. County		10c. Ci	ity, Town or L	ocation						1	Od. Inside	City Limits
	4 sho	Maryland	Montgo	merv	Wh	eaton								2.2	es 2 No
3	or zite-fra be notified Directo	10e. Street and Nu		1102)	*****		10f. Z	ip Code				10g. Citizen of V	Vhat Cour	ntry?	
ames		2903 Kir	ngswell	Drive			20	0902				United	State	2.5	
13	ur, or hems 23a Camboer must by Funeral	11. Marital Status 1 Never Man	ried 2 📉 Marrie	12. Was Dec Armed F ad 1 Yes If Yes, G	2 XNo	J,S. 13.		edent of H ecify Cuba	lispanic Orig an, Maxicen Specify:	gin? (Specif i, Puerto Ric	fy Yes or No- can, etc.)	14. Rec Blac Specify	k, White,		716
00		3 Widowed		Year or I	Dates:	16a Daga	donto Ha	ual Oasun	ation			16b. Kind of Bu	Blac		
Wendo / yn Maryland 21215-0020	ad within 72 ho typiens. Ner than "nature it, the Medical. Completed	(Spe Elementary/Sec		grade completed)) (1-4or 5+)	(Give		vork done i use retired	during most			Market		Justry	
900	C A S	17. Father's Name	(First, Middle, L	ast)		Kegi	Onar	Jare			First, Middle,	Maiden Sumam			
19 Ian	hantal H had off Ic even o Be	Quinton								len B					
any	N pund N	19a. Informant's N	ame/Relationsh	lp (Type, Print)		19b. Mail	ling Addres	ss (Street	and Numbe	er or Rural F	Route Numbe	er, City or Town,	State, Zip	Code)	- Dillia
CP .	Spin and	Lolita 3	James Ma	rtin, da					reek	Court	, Bowi	e, Mary			
eleh (If Hen or oth		Cramation	3 ☐Removal from	State	Place of Disp cemetery, cre	matory or	other plac			Date	20c. Location -			
る計	Semil. Pa Separtment mportanti any Injury atics.	4 Donation	/5 ☐ Other (Sp	-	F	t. Lin			tery		12/00	Brentw	ood,	Mary	land
le/e Ba	O O O O O O O O O O O O O O O O O O O	MI	4/1	11/9	1/2	_ M	cGui	re Fu	neral	Serv	ice, I	nc. shingto	n. D.	. C.	
1	TO SHARE	Ma. Part1. Enter shock, or he	the disaase, or o	complications that	caused the dea	th. Do not en	nter the mo	ode of dyin	ng, such as	cardiac or r	respiretory a	rrest,	11, 1	Approxin Interval	Between
0	Physician /Medical	Immediate Cause disease or conditi	(Final											11-	nd Death
100	Examiner	resulting in death)	114		Cutc Due to (or es a conse	equence of	j):				-341	1		
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ć	cate be executed physicien and the burial-transit che burial-transit checking Examination of the contraction	Sequentially list of if any, leeding to it cause. Enter Und Cause (Disease o	onditions, mmadiate	Bu ef	Dua to (or as a conse	equence of	i):							
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٥.	The lew requires that the death certificate has been signed by the attending page 2 should be detached for use as Completed by Physician/Me	SA	wcolde	2/50					. 200		10	Yes 2 No	3 Pro	bably 4	Unknown
rds	v requires been sign should by										24e. Was	an autopsy	av	ailable pri	sy findings or to
900	The lew require page 2 should Completed									_			of	mpletion death?	of cause
<u>=</u>											10,	Yas 2 No	1 [☐ Yes 2	2□ No
Vita	entific ector Be	25. Was case refe - axaminer?		Hospital:		,		Oth	or:		Check only o				
o	T T	1 ☐ Yes 2 ☐ 27. Mennes of Dea		28a. Date		ER/Outpatie		JUA	4 LI NU			dence 6 Oth		y)	
e e	St. St.	1 🖾 Natural 2 🗆 Accident	5 Pending	(Mor	nth, Day Year)	Injury	M	Wor	rk? Yas 2□			non mjory occas			
Division of Vital Records, P.O. Box	Patrice Te	3 Suicide 4 Homicide	6 Could n	ned 288. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, si	treet, facto	ory, office		28	of. Location (: City or Tox	Street and Numb vn, State)	oer or Run	al Route N	lumber,
	To the Hospital within 24 hours. To the Funeral completely filled	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the examiner: On the b and msr	e best of my kno pasis of examina nner stated.	owledge, deel ation and/or in	th occurre nvestigatio	d at the tir	me, date an opinion, dea	d placa, an th occurred	d due to the fat the time,	cause(s) and me date and placa,	enner as a and due to	tated. o the caus	se(s)
	To the Comp	29b. Signature and					2	9c. Licens	e number			29d. Data signe	d (Month,	Day, Yea	r)
	12	1 20	in T	wally To	- Mi).		DOI	042	684		August	- 5,	200	O
		30. Name and add	ress of person w	no completed cau	se of death (tte			ıro1	Max	land					
	State	31. Date filed (Mg/		M.D., 57	Pegistrar's Sign		, Lat	,	Haly	Land	20/0/				
	Bagistror	A	UG na	2000	Leneva	19	1	20. 1.							

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State of Maryland / Department of Health and Mental Hygiene

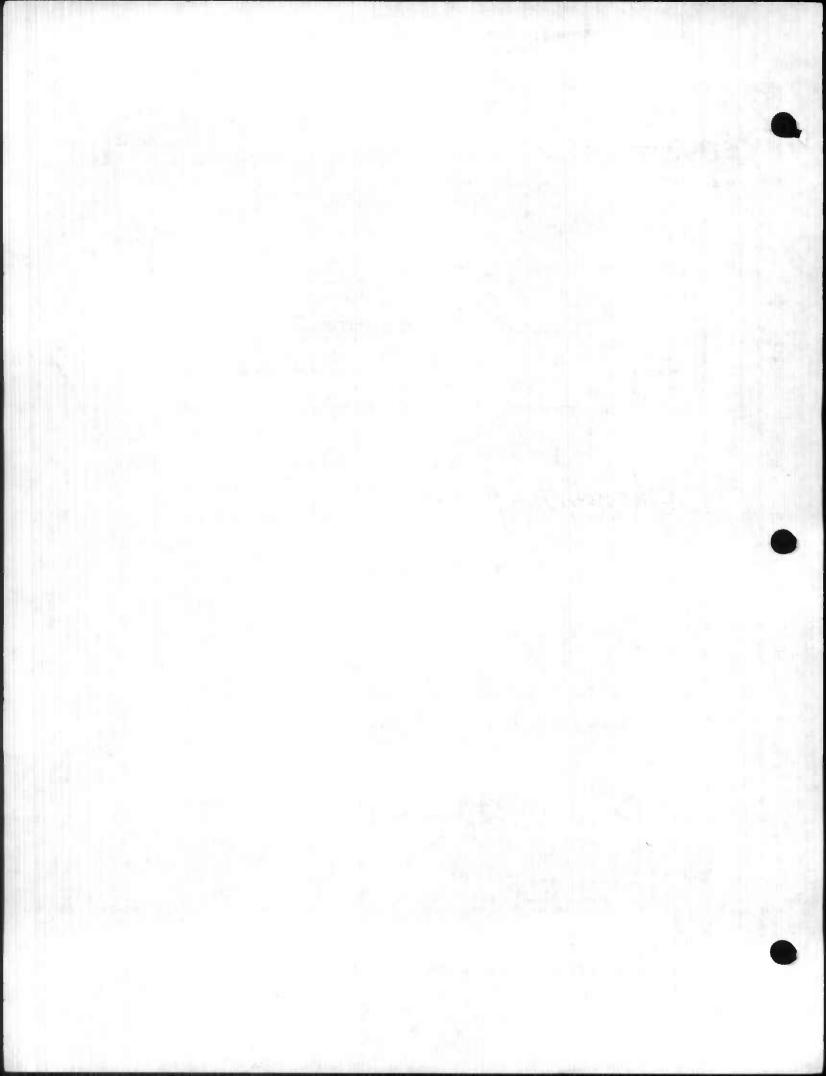
Certificate of Death

						Cei	uncate c	שם זכ	aın		Reg. No.		
п	Dhamining	1. Decedent's Nam	ne (First, Middle, I	ast)						2. Date of De Month		Year	3. Time of Death
	Physician /Medical	CHARLES	ELMER .	JONES						AUGUST	7, 2000) ' ' ' '	2:00 AM
	Examiner	4a Facility Nama (If not Institution, g	iva street and n	um <i>ber)</i>			4b. C	City, Town, or Lo	ocation of Death	4c. County	of Death	
		SUBURBA	AN HOSPI	ral				BET	THESDA		MONTGO	DMERY	
-	Funeral	5. Social Security N	Number 6	Sex	7. Age (In yrs.	last birthday)	It Under 1 Ye		Under 24 Hrs.	8. Date of Bir	th Vacal	9. Birthp	aca (Stata or Foreign
	Director	579-18-4	4652	™ 2□ F	78	Yrs.	Months Da	lys H	lours Min.	8. Date of Bir (Month, Da Jan 3	1, 1922	Wash	ington, D.
ь	70	Usual Residence o	f Decedent										
	and an other state of an other	10a. State	10b. County		10c. City	y, Town or Lo	cation					10	Od. Inside City Limits
	Mar Mar	Maryland	Montgo	mery	Whe	aton							1√ Yas 2□ No
	or 28s-f s be notified Director	10e. Street and Nu			41.11.1		10f. Zip Coo	ie			10g. Citizen of V	What Coun	try?
		11742 V	iers Mil	Road			20902			10.00	United	Stat	es
	r thems 23 inner must Funeral	11. Marital Status		12. Was De	cedent Ever in U,	S. 13. V			nic Origin? (Sp laxican, Puarto	ecify Yes or No	- 14. Rac	e - America	
_	Fur Fur		ried XXMarried	Armed F	Forces? 2 No 194	3-				Rican, etc.)	Blac	ck, Whita,	
350	or o	3 ☐ Widowed	_	If Yes, G	ive 10/		□ Yas 2	No S	pecify:		Specify	Bla	CK
ŏ			15. Decedent's	Education		16a, Deced	lent's Usual Oc	cupation	1		16b. Kind of Br	usiness/Ind	lustry
15	ad within 72 ho ygens. we than "naturn 4, the Medical Completed		cify only highest g	rade completed		(Give	kind of work do	one durin	g most of work	ing			
212	with the stand	Elementery/Second	ondary (0-12)	College	(1-4or 5+)	Libr	ary Tec	hnic	cian		Federal	L Gov	ernment
P		17. Fathar's Name	(First, Middle, La	st)				18.	Mother's Name	e (First, Middle,	Maiden Suman	10)	
an	d be	Robert	A. Jones					1	Blanche	Brooks			
2	d Men d Men matte To	19a. tntormant's N		(Time Brief)		105 Mailir	a Address /St				er, City or Town,	State Zin	Code)
Maryland 21215-0020	79 and 19		M. Jones		Wife				ll Road			2090	_
	test test	20a. Method of Dis					sition (Name o		LI ROAU	Date	20c. Location -		
0	1010	**	Cremation 3	□Removal from	n State	emetery, crer	natory or other	piace)	2 1 0				
E	Pa mon mon man	4 □ Donation	5 ☐ Other (Spec	cify)	Pa	rklawn	Memori	lal .	Park 8	/11/00	Rockvi	ile,	MD
Baltimore,	Separation of the separation o	21. Signature of Fi	uneral Service Lic	ensee / //	0	22 M	Nama and Ad	Filme	Facility eral Se	rvice.	Inc.		
B	25228	Mu	mas,	JUL	jours	^						on D	.C. 20012
П		23a. Part1. Enter shock, or hea	the disease, or co	mplications 4	caused the death							1	Approximate
	Physician	shock, or hea	art tailure. List on	ly one causi on	each tine.								Interval Between Onset and Death
	/Medical	Immediate Cause	(Final		0		0.	0				i	110
	Examiner	disease or condition resulting in death)	on	a	Nescy	atomy	tai	lu	1			1	4 day
		100			Due to (o	r as a consec	uenca ot):						2, 0
	nin min			b		LUND						i	4 day
	rate be executed hysician and the burial-transit dical Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or that initiated event	onditions, mmediate		Due to (o	r as a consec	uenca of):					i	•
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9 xc	ding gase as			l d									
Bo	attence I for us											1	
	0 0 0	Part it. Other signi	ficant conditions	contributing to	death but not rase	ulting in the u	nderlying cause	a given ir	n Part I.	23b. Did	tobacco use co	ntributs to	the cause of death?
P.0	that the ed by th detach	De 1		1						10	Yes 2 No	3 Prof	bably 4 Unknown
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Records,	been sign should be										an autopsy	24b. We	ere autopsy findings ailable prior to
S	aw requires been 2 should									pont	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CO	mpletion of causa death?
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of Vital	Physician: this certific ral director,	25. Was case referance?	/	Hospital:				Other:	. Place of Deat				
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E C	After funer	1 Divetural	5 Pending	(Mo	e of tnjury onth, Dey Year)	28b. Time of Injury		tnjury at Work?	0 🗆	200. Describe	now injury occur	100	
Division	r death. ector: After by the fune	2 Accident 3 Suicide	investigat	he					2 No				
2	r Att	4 Homicide	determine	208. Plac	ca of Injury - At ho ding, etc. (Specif)	ome, tarm, str v)	eet, fectory, off	lica		28t. Location (City or To		ber or Hura	i Route Number,
0	No Hospital or Attending P no 24 hours after death. No Functal Director: After tpletely filled in by the funeraction: edical Certification:			15									
	Hospital 24 hours Funeral (tely filled	29a. Certifier (Check only	1 Certifying	Physician: To the	ne best of my know basis of examine	wiedge, death	occurred at th	e time, o	dete end placa,	and due to the	cause(s) and m	anner es si	teted
	Plete	one)	Z MOUTON EX		innar stated.	non and or m	restigation, in i	пу оринс	on, deem occur	red at the time,	date and piece,	2110 000 10	tire cause(s)
	To the Hoaptal or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and	title ot certifier			1.74	29c, Lic	cense nu	ımber		29d. Date signe	d (Month,	Day, Year)
		1 m	nella	^			1)	05	1714		8-7	1-00	0
	8	30. Name and add	rese of person wh	o completed as	use of death (tto-	23e1/Tune	Print) 9 (A	01	ROAD	and	Blind	IL	100
				City	110	. 20a/ (Type,	0	- 10		111	0 -6	U	102
		JATINDO 31. Date tiled (Mon		- 0 (Registrar's Signa	turo	K	250	ru	100	1 200	70	
	State ⊪Registrar	A A	LIG 1 0 2	000	Column Solyila	19	done	1/21					

08-01-00

CHARLES

JONES,



State of Maryland / Department of Health and Mental Hygiene 00 26763 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey August 8, 2000 6:40 AM King 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Cheverly, Prince Georges Prince Georges Hospital If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2X F Months Days Hours Min. Yrs. Dec 17, 32 1967 Washington, DC Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits 1.□ Yes 2□ No Maryland Prince Georges Suitland, 10f. Zip Code 10g. Citizen of What Country? 3319 Navy Day Drive 20746 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ∑No tf Yes, Giva Yaar or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNaver Married 2 Married 1 ☐ Yes Ž ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Private 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Arthur Prather Joann King 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Joann Brown / Mother 3319 Walters Lane, Forestville, MD 20746 20b. Placa of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/14/2000 Landover, MD 21. Sigrutury Funeral Service Licensee 22. Name and Address of Facility
Pope Funeral Homes 5538 Marlboro Pike, Forestville, MD 20747 umos Approximate Interval Between Onset and Daath y sans

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

than "natural", or itema 23s or the Medical Examiner must be a

7 is marked other traumatic avent,

item 27 li

permit. Page Department of important: if any injury or once.

= 0

Directo

Funerai

by

Completed

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Lashaun A.

5. Social Security Number

579-94-2135

10e. Street and Number

12

20a. Method of Disposition

25. Wes cesa referred to medical examiner?

5 Pending

investigation

6 Could not be

1 ☐ Yes 2 No

27. Mannar of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

11. Marital Status

10a State

Examiner physician end the bunal-transit Physician/Medical attending pl signed by the þ Completed Be Certification: To

law requires that the death certificate be executed P.O. Box 68760. Records, is certificeta had The Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, it

To the Hospital within 24 hours a To the Funeral C completely filled

State Registrar

edicai

arre Part Enter the drease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failura. List only one cause on each line. Immediate Ceuse (Finel Human Immunodeficiency Virus disease or condition rasulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Dua to (or es a consequence of):

28b. Time of

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Dey Year)

24b. Were autopsy findings evallable prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inveatigation, in my opinion, death occurred et the time, date and placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

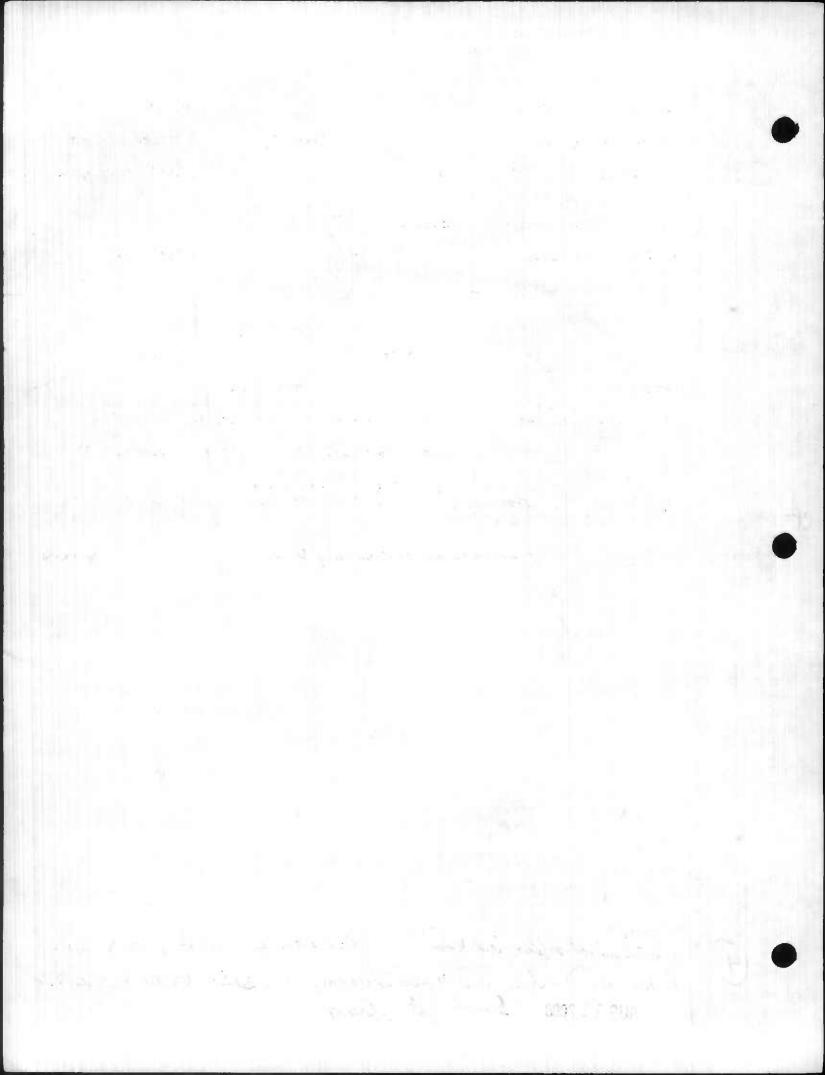
2Qc. Licensa number 001852

29d. Date signed (Month, Day, Year) August 8 2000

23b. Did tobacco use contributa to the ceuse of death?

3 Probably 4 Unknown

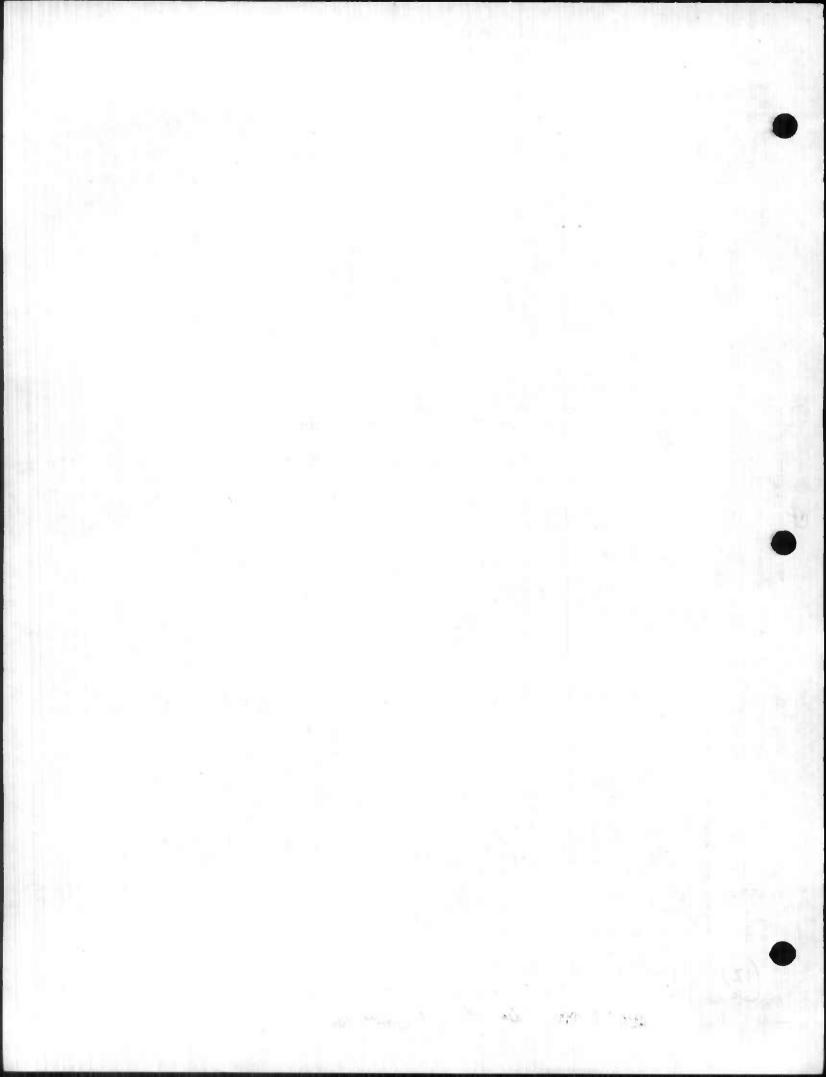
DE VORE MD 4203 QUEENS 5-ry Rel Hey 4 HSVILL MD 20781



State of Maryland / Department of Health and Mental Hygiene

26764

ROBERT LEE	EKERNS	Siai	e Of Marylar		tificate of			eg. No.	0 26761	1
	1. Decedent's Name (First	, Middle, Last)					2. Date of Deel	th	3. Tima of Death	1
Physician /Medical	Robert Le	e Kerns					AUG.	Day 5, 2000	1612 P	M
/wedical	4a Facility Name (If not in	stitution, give street an				4b. City, Town, or	Location of Death	4c. County	of Death	
	2308 FLOR	AL PARK ROA	D D			BRANDYW	INE	PRIN	CE GEORGES	
Funeral Director	5. Social Security Number 219–48–0970	6. Sex M 2□	7. Age (In yrs. 51	last birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min		Year)	Birthplaca (State or Fore Country) Maryland	ign
p .	Usual Residence of Deced		1400 0	h. Tour or los	-1:				10d. Inside City Lim	***
ahow ahow		County		ity, Town or Loc					1 Ves 25	
ior 28a-f a	MD	P.G.	C	amp Spr	_			On Ohion of M		b
Dir Dir	10e. Street and Number				10f. Zip Code 2074	10		0g. Citizen of V		
e 23	6110 Marl:		Decedent Ever in U	10 12 14		Hispanic Origin? (5		Jnited :	States - American Indien,	
5-0020 72 hours after deeth with the Maryland natural, or flame 23a or 28a-f ahow ore Examiner naust be notified at seed by Funeral Director	11. Maritel Stetus 1 Never Merried 2 3 Widowed	Arme ☐ Married 1 ☐ \	d Forces? 'es 2 ☐ No s, Give or Dates:	01	Yes, specify Cub	en, Mexican, Puer	to Rican, etc.)		k, White, etc.	
15-002 72 hours "natural".	15. De	ecedent'a Education		16e. Decede	ent's Usual Occup	pation	45.5	16b. Kind of Bu	sinass/Industry	
	(Specify only	highest grade comple	ted) ge (1-4or 5+)	- (Give k	ind of work done O NOT use retire	during most of wo	rking			
d within giene.	12	0-12)	98 (1-401 54)	Electi	rician			Self I	Imploved	
re, Maryland 212: 1 end 2 should be filed within it Health and Mental Hygiene. 1 them 27 is marked other than other traumatic event, trail. To Be Comp	17. Father's Name (First, I						me (First, Middle, I		e)	
larylan 2 should be and Mentel 8 marked o	James Ric	chard Kerns	5			Leona M	lae Bodin	9		
Maryland de file de should be file the and Mental Hy 7 is marked oth traumatic event	19e. Informent's Neme/Re	elationship (Type, Print)					ural Route Number			
e, M 1 and 2 Health m 27 I	Christina K	erns (DAUG				Street, (rlando,	Florida	32803	
	20a. Method of Disposition	nation 3 Removal f		Place of Dispos cemetery, crem	ition (Neme of atory or other ple	(0)	Date	20c. Location ·	City or Town, Slate	
Pages nent of l	4 Donation 5 0			Inion Ce	metery 2	Aug 11,	2000	Leesbur	g, Virginia	
Baltimo	21. Signature of Funeral S	ervice Licensee		22.	Name and Addre	ess of FecilityLe	e Funeral		Inc 6633 Old	
00 88 28 8	1. 91	2: n (fatter	_ Al	lexandri	a Ferry	Road, Cli	nton, M	laryland 2073	5
	23a. Part1. Entar the disa shock, or heart lailur	ese, or complications the	hat caused the dae	th. Do not ante	r the mode of dyi	ing, such as cardia	c or respiretory arr	ast,	Approximata Interval Between	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· 1	Terro S. Dua to (or as a consequence	vance of):	listyc	dor d Di	Disea	Onset and Death	
x 68760, entiticate be executed sing physicien end se as the burial-transit Medical Examiner	Sequentially list condition if any, leading to immedie cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest	c		or es e consequ			(
P.O. Box 6 at the death certific the by the attending petached for use as	Pert II. Other significant of	onditiona contributing	to death but not res	sulting in the un	derlying cause gi	iven in Part I.	23b. Did to	obacco uae co	ntribute to the cause of dea	nth?
C X TO							1 🗆 Y	2 No	3 Probably 4 Unkn	own
COrd requir							24a. Wes a perfor	n autopsy med?	24b. Wara autopsy finding available prior to completion of cause of death?	gs
The law page 2	THE THE THE						NEY	es 2 No	1 Tyes 2□ No	
Vital Indicate certificate rector, pag	25. Was casa referred to	medical				26. Piaca of De	ath (Check only or	na)		
- x = 5	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	1 Inpatient 2	ER/Outpatient	3 DOA Ot	her: 4 Nursing	Homa 5 Resid	enca 6XOth	ar (Spacify) AT SCEN	Œ
After tune	Accident	Pending investigation	hate of Injury Mainth, they Year)	28b. Time of Injury	28c. Inju Wo	ry at ork? Yes 22No	28d. Describe h	ow injury occur	1 - 1	4
Vis Ante pr de ecto by th	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be datarmined 28e.	Plece of Injury - At houlding, atc. (Speci	nome, farm, atre	et, factory, office		28f. Location (S City or Tow	treet end Numb	er or Rurel Route Number,	
Ce in part of in Ce			onemy, and topoon	" TRE	727		2308 F	oval 6	rk RD 2073	55
ne Hospi n 24 hou ne Funer pletely fill edical	29a. Certifier 1□ C	ertifying Phyelcian: To edical Examiner: On t and	tha best of my kno he basis of examina manner stated.	owledga, death ation end/or inv	occurred at the ti estigation, in my	ime, date and plac opinion, death occ	a, and due to tha c urred at the tima, o	ausa(s) and ma late and placa,	nner as stated. and due to the cause(s)	
To the within within to the compound of the co	290. Signature and title of	Certifier			29c. Licen		2		d (Month, Dey, Year)	
	1000	Tole M			0.	C.M.E		AUG.	7, 2000	
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Registrar	AUG 1	0 2000	ze eva		ports	•				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 2000 KRUG 4:30 AM HELEN AUG 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HOME MONTGOMER! WINERAN KOCKVILLE Social Security Number 7-03-3830 Hours Min. 8. Date of Birth Month, Dey, If Under 1 Yeer Months Deys 6. Sex 9. Birthplace (State of Foreign 1 M 2 F Usual Rasidenca of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? VEIRS 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. Never Married 2 Married 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) EDUCATIO LI EACHER SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meldan Surneme) KRUG HARAY REY ANAF 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number. City or Town, State, Zip Code) REV. DR. KEICHARD-EXECUTOR-9701-(EIRS VOCKUILLE, 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca 20a. Method of Disposition 20c. Location - City or Town State Burlal 2 Cremation 3 Removal from State AUGIO HANOVER 4 ☐ Donation 5 ☐ Other (Specify) HYSONG CO, TH 21. Signature of Funeral State Licensee ST., WW plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart feilure. List only immediata Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting In death) Last heimen's Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary Arley Buseauch 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2/2 No 1 ☐ Yes 2 ☐ No 25. Was case rafarred to medical examiner? 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or

Physician

/Medicai

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Pages 1 end 2 should be filed within 72 hours efter death with nent of Health end Mentel Hygiene.

snt: If Item 27 is marked other than "natural", or items 23a or lary or other traumatic event, the Medical Examines must be it.

Baltimore, Maryland 21215-0020

Director

Completed by Funeral

Be

Physician/Medical Examiner Be Completed by P

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital or Attending Physician: nours efter death.

neral Director: After this
filled in by the funeral di

To the Hospital o within 24 hours of To the Funeral D completely filled I

Registrar

Medical

29b. Signature end title of curling

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describa how Injury occurred

30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print)

OR. C. SCHEMM - 9.701 -

5 Pending investigation

6 Could not be datarmined

28a. Data of Injury (Month, Dey Year)

EIRS DR. POCKULLE,

31. Date filed (Month, Dey, Year)
AUG 0 9 2000

27. Mannar of Daath

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicida

32. Registrar's Signature

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify)

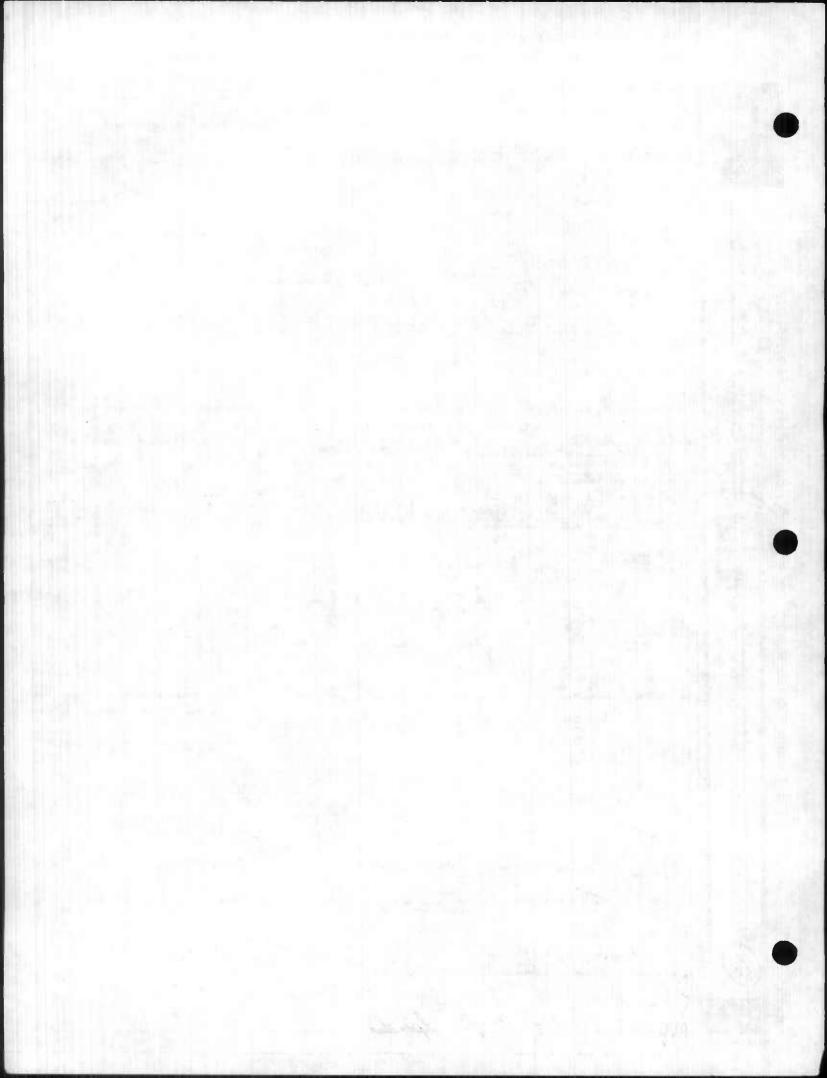
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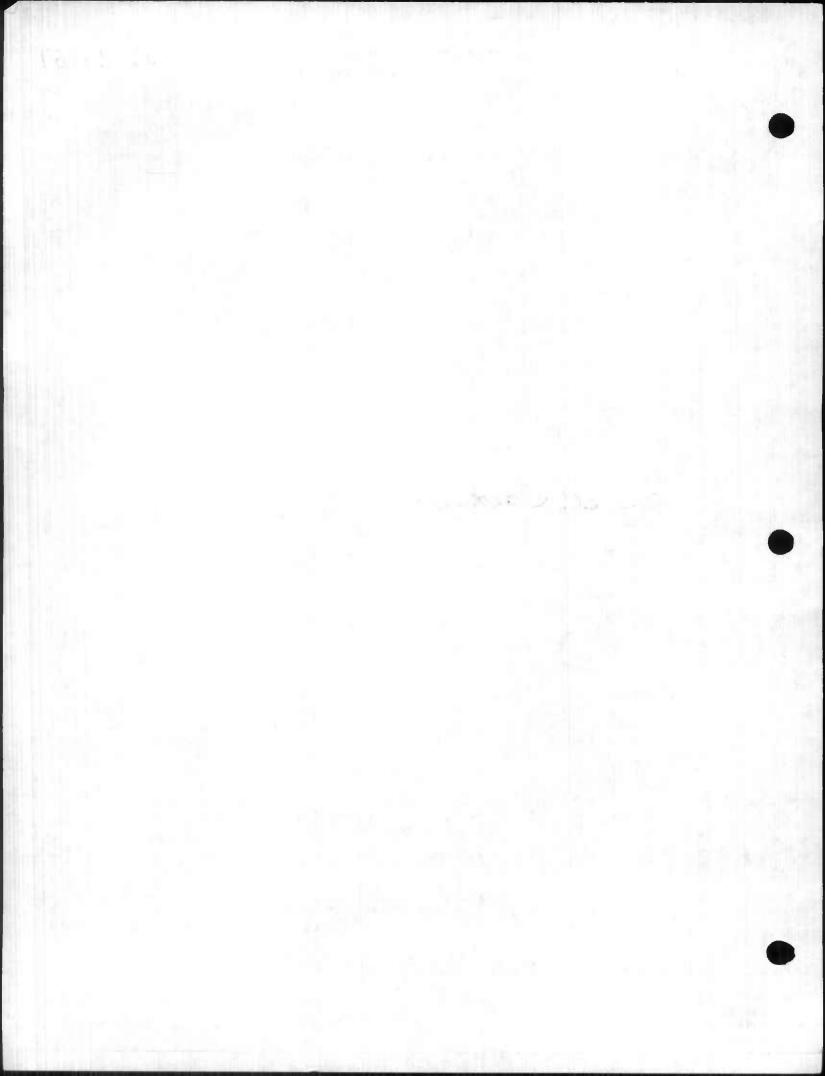
DHMH 16 Rsv 6/95

Registrar



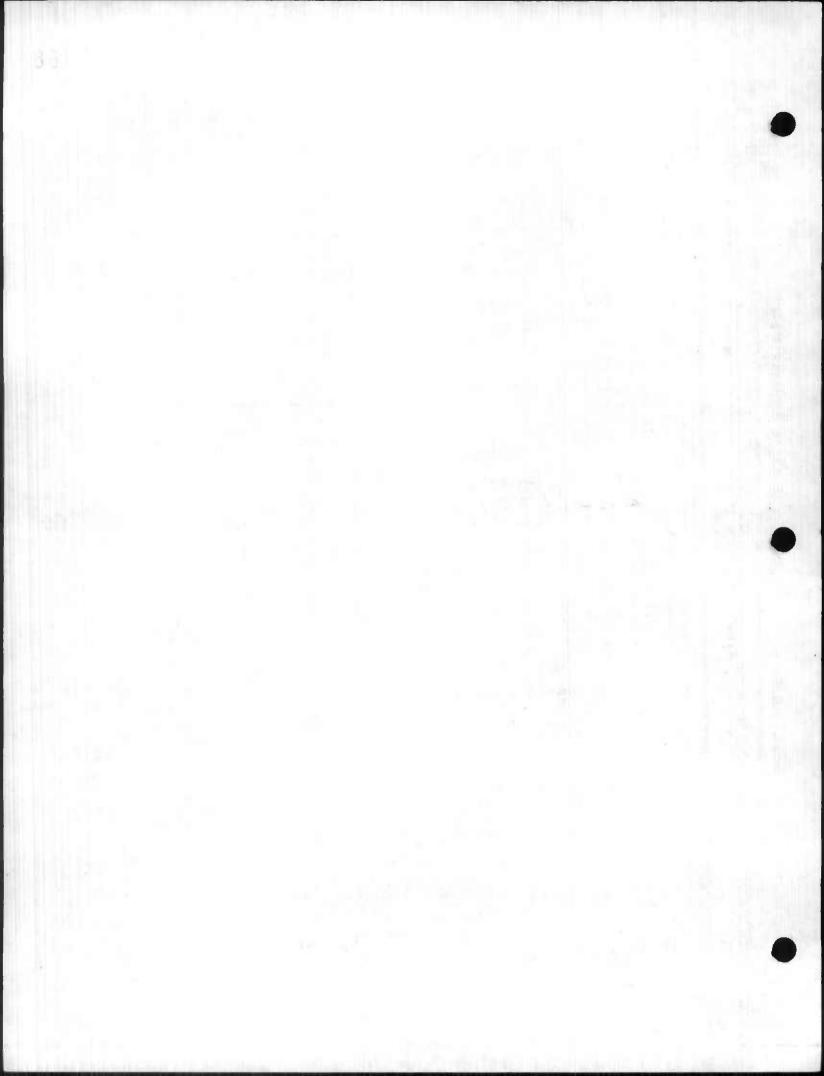
State of Maryland / Department of Health and Mental Hygiene 00 26767

Amedned item	# 8 per FH G786 8-30-00	WJJ	Certifica			Reg. No.	2016.1
Physician	1. Decedent's Nama (First, Middla, Las	()	Miles .		14-	a of Death	3. Tima of Death
Physician /Medical	FLORENCE G. KRAU				AUGU	ST 7,2000	6:10 PM
Examiner	4a Facility Nama (If not Institution, give HOLY CROSS HOSPIT				City, Town, or Location of SILVER SPRI		r GOMERY
Funeral Director	5. Social Security Number 6. Security Number 11		Yrs. If Under Months		Under 24 Hrs. 8. Data Hours Min. NO	a of Birth 11-1-14	9. Birthplaca (Stata or Foraign NEW YORK
Meryland -f show	Usual Rasidence of Decedant 10a. Stata 10b. County MD . MONTGOMER		Town or Location VER SPRIN	G			10d. Insida City Limits 17☐ Yas 2☐ No
h with the Mer 13e or 28e-f si at on notified		RIVE	12.0	964-18	50	10g. Citizen of	What Country?
d 21215-0020 diled within 72 hours after death with the Meryland hygiene. ther than "natural", or items 23s or 23s-1 show ent, the Medical Exercise must be notified.	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Evar in U,S Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas:	5. 13. Was Dec if Yas, sp 1 ☐ Yas	**	anic Origin? (Specify Ye Maxicen, Puarto Rican, i Specify:	s or No- atc.) 14. Rac Bla Specifi	ce - American Indian, ck, Whita, etc. WHITE
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumetic event, the Hedical Elemin To Be Completed by F	15. Decedant's Ed (Specify only highast grader) Elementery/Secondery (0-12)	ucetion da completed) Collega (1-4or 5+)	16a. Decedent's Us (Giva kind of w life. DO NOT MERCHANT	ual Occupatio ork dona duri use ratired)	n ng most of working	16b. Kind of B	usinass/Industry GROCER
laryland 212; 2 should be filed within and Mental Hygiene. Is marked other than numatic event, the Memmatic event, the Memmati	17. Fathar's Nama (First, Middla, Last)			18	Mother's Neme (First, SARAH LEV		na)
Maryle and 2 should eith and Men 127 is marke or traumatic To	19a. Informant's Name/Relationship (7 CHARLES KRAUS	iype, Print) HUSBAND	19b. Mailing Addra 12400 PALE	ss (Street end RMO DR	Number of Rurel Route , SILVER SE	Number, City or Town, PRING, MD.	State. Zip Code) 20904
Baltimore, N permit. Pages 1 and 1 Deportment of Heelth Important: If Item 27 1 any Injury or other tr once.	20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specify	Ramoval from Stata	ace of Disposition (Normatary, cramatory or LEBANON		AUGUS	ST	City or Town, Stata
Ball permit Import Import any In	21. Signature of Funaral Service Licentification of Funaral C.	Stattlemen	DANZANS	CKVILL	DBERG MEMOR	VILLE , MD.	
Physician	23a. Part1. Entar the disaasa, or comp shock, or haart failura. List only of	ona ceuse on each iina.	. Do not aniai tria m	ou or cynig, c		atory arrost,	Interval Between Onsat and Death
/Medical Examiner	Immediate Causa (Finat disaasa or condition resulting in death)	a. intracer	ebral hemo	rrhage	n.		2days
خِ الساسا			as e consequence of ascular di				
68760, ifficate be executed g physician and es the bunal-transit edical Examiner		b	es a consequence of				
	rasulting in death) Last	Due to (or d.	as a consequanca of):			
Geeth certification of attending post for use estimated for use es	Pert II. Other significant conditions co	onfributing to death but not resul	Iting in the underlying	causa givan i	in Part t. 23	b. Did tobacco usa co	ontribute to the cause of death?
COLDS, P.O. BOX v requires that the death cent been signed by the attending should be detached for use of							3 Probably 4 Unknown
II Records, P.O. Box The law requires that the deeth cent late has been signed by the attendin page 2 should be detached for use. Completed by Physiclen/M					24	e. Was an autopsy performed?	24b. Wara autopsy findings available prior to complation of causa of death?
Vital Rec						1□ Yas 2√2 No	1 ☐ Yas 2 ☑ No
Of VITAL Physician: The Physician: The ribis certificate and director, page 1: To Be Co	25. Was cese referred to medical axaminar?	Hospital:		Other	6. Place of Death (Chec		
Division of Vital Records, to attending Physician: The taw requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	TILI TAS ZIXINO	28a. Data of Injury (Month, Day Year)	ER/Outpatient 3 6 28b. Time of Injury	28c. Injury at Work?	4 Nursing Homa 5 28d. Do	ascribe how Injury occu	
Division of attending P as after death. In Director: After the din by the funers Certification:	3 Suicide 6 Could not be datarmined	28a. Ptace of Injury - At hor building, etc. (Specify)	ma, farm, street, facto	ory, office	28f. Lo	cation (Street and Num y or Town, Stata)	ber or Rural Routa Number,
he Hospil in 24 hour he Funer pletely fill edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my know iner: On the besis of examination and manner stated.				e tima, date end ptace,	and dua to the ceuse(s)
Within Some	29b. Signatura and title of certifiar	Mou		9c. Licansa n D43228	umber		ed (Month, Day, Year) -08-2000
	30. Nama and address of person who of DR. LYNETTE POSOF	RSKE 8630 fent	on st. si	lver s	pring md.	20910	
State Registrar	31. Data filed (Month, Day, Year) AUG 10 20	32. Registrar's Signati	g. A	rocks			



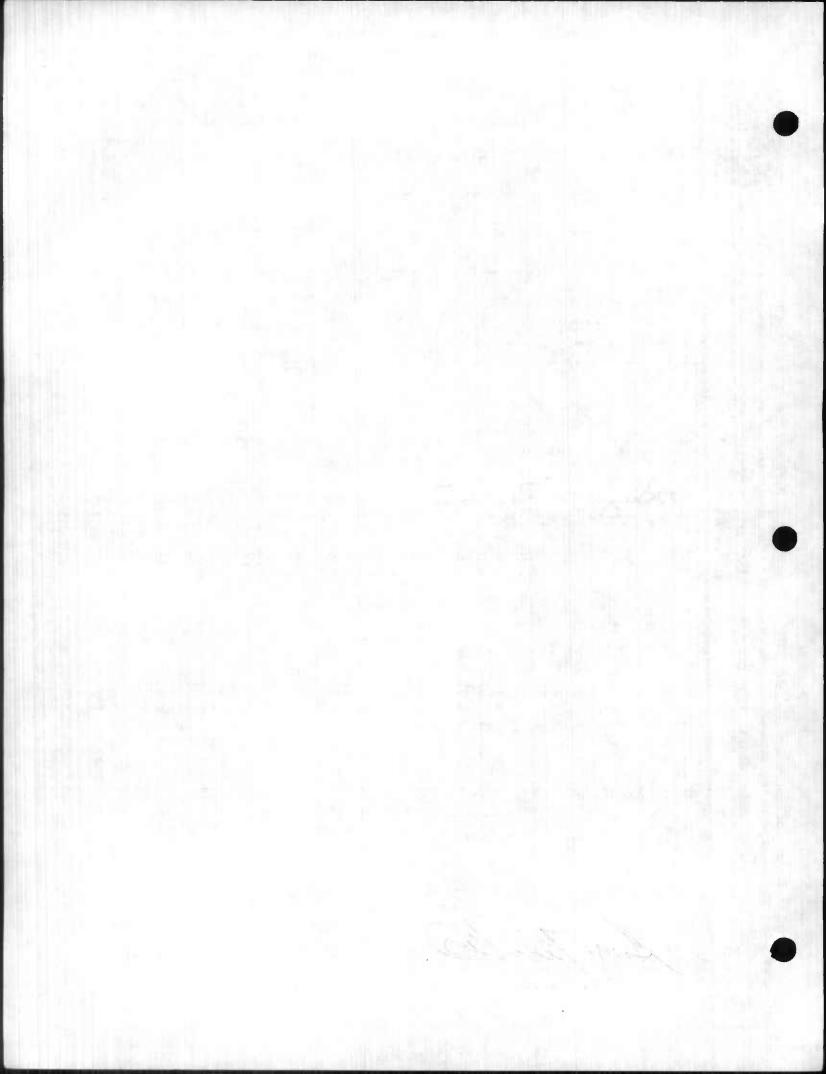
State of Maryland / Department of Health and Mental Hygiene

		nt's Nama (First, Midd	dle, Last)						2. Data of De Month	Reg. No.	Year	3. Tima of Death
ician dical	VIII	ginia	Hampton	1	Kramer				August			12:30 PM
iner	4a Facility	Name (If not Institution		and number)			- 1	b. City, Town, or		h 4c. Count	y of Death	
_,		urban Hosp:				1 #11 4	4.7/	Bethesd			gomery	
	558	Security Number -12-8510	6. Sex 1 M 2		yrs. last birthday 79 Yrs.	Months	Days	If Under 24 Hrs Hours Min.	6. Data of Bi (Month, Di Oct.	15, 192	9. Birthplac Country	ce (State or Foreig Utah
	10a. State		у	100	c. City, Town or L	Location					100	I. Inside City Limits
tor	Md.	Mont	gomery		Bet	thesda						Y□ Yas 2□ No
Funeral Director	10e. Street	t and Number				10f. Zip	Code			10g. Citizen of	What Country	17
	9707	Old Georg	getown I	Road		20	0814			USA	A	
	3 [2 €w	l Status ever Merried 2 ☐ Mar idowed 4 ☐ Divorceo	rried 1 [as Decedent Ever med Forcas?] Yas 2∑ No ′es, Give ar or Datas:	in U,S. 13.	Was Deced If Yes, spec		lispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	14. Ra Bla Specil	ce - American ck, Whita, etc	
		15. Decedar (Specify only highe	nt's Education	nlatad)	16a. Deci	edent's Usua	I Occup	ation during most of wo	rking	16b. Kind of B		stry
-	Elemen	tary/Secondary (0-12)	1	llega (1-4or 5+)						Roanok Cathol	_	ools
	17. Fathar	's Nama (First, Middle,	(ast)		SCHOOL	ol Tea	chei	18. Mother's Nar	na (First Middle			0010
-		Mundell		npton					an Davi		,	
2	19a. Infor	mant's Name/Raiations		•	19b. Mai	iling Address	(Street	and Number or Ri			, State, Zip C	ode)
	Cathe	erine Henry	y/daugh	ter	4914	4 Glen	broo	ok Rd., NV	V.,Washi	ngton, D	.C. 20	016
		od of Disposition	0.00		Ob. Place of Disp	position (Name	ne of ther plac	ce)	Data	20c. Location	- City or Towr	n, Stete
		urial 2 Cramation onation 5 Othar (5		il from Steta	St. And	rew's	Ceme	etery	Aug.5,00	Roano	ke, Vi	rginia
	21. Signa	ture of Foneral Service	Licensee	010				ss of Facility eral Home				00007
	230 Paril	Entar tha disaase, o	(A)	04				onsin Ave				20007 poroximata
lner	resulting	n daa(n)					on				1	
			b	Arteri	to (or as a conse osclerot	equence of): tic Vas		ar Disea	se		1	
al Exam	Cause (D	Illy list conditions, ding to immadiata iter Undarlying seasa or Injury	b	Arteri	osclerot	tic Vas		ar Disea	se			
edical	Cause (D that initiat rasulting i	Illy list conditions, ding to immadiata iter Underlying seasa or injury ed evants n death) Last	6	Arteri Dua Diabet	osclerot	equenca of):		ar Disea	se			
	Cause (D that initiat rasulting i	n death) Last		Arteri Dua Diabet	osclerot to (or as a conse es to (or as a conse	equence of):	scul			tohacco use co	patribute to t	ha cause of death
	Cause (D that initiat rasulting i	BO evants	ons contributin	Arteri Dua Diabet	osclerot to (or as a conse es to (or as a conse	equence of):	scul		23b. Did	tobacco use co	ontribute to ti	he cause of death
	Cause (D that initiat rasulting in Part II. Oth	er significant condition	ons contributin	Arteri Dua Diabet	osclerot to (or as a conse es to (or as a conse	equence of):	scul		23b. Did 1 □		3 Probe	bly 4 Unknown a autopsy tindings able prior to bletion of cause
	Cause (D that initiat rasulting in Part II. Oth	n death) Last er significant condition pertension	ons contributin	Arteri Dua Diabet	osclerot to (or as a conse es to (or as a conse	equence of):	scul		23b. Did 1 □ 24a. Wes	Yas 2□ No	3 Probal 24b. Were availa comport de	bly 4 Unknown a autopsy tindings able prior to bletion of cause
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be completed by Physician/Medical	Cause (D that initial rasulting in Part II. Ott	er significant condition pertension roke	lons contributin	Arteri Dua Diabet Dua	osclerot to (or as a conse es to (or as a conse	equence of): underlying ca	scul	en in Part I. 26. Place of De	23b. Did 1 □ 24a. Wesperi	Yas 2□ No s an autopsy omed?	24b. Were available comp of de	e autopsy tindings able prior to oletion of cause ath?
to be completed by rugsicial ymedical	Part II. Oth Hy St 25. Was c aximin 1 D Ne	pertension roke asa raferred to medica ar? so 2 \(\) No r of Death tutural 5 \(\) Pendii invasti uicida 6 \(\) Could	al Hospital	Dua Diabet Dua g to death but no	osclerot to (or as a conse es to (or as a conse to resulting in the 2 ER/Outpatie ar) 28b. Tima	equence of): underlying call ent 3 DO of 26	ausa giv	en in Part I. 26. Place of De	23b. Did 1 □ 24a. West perf 1 □ ath (Check only tome 5 □ Res 28d. Describe	Yas 2 No s an autopsy ormed? Yas 2 No one) idence 6 □Ott how injury occu	3 Probei	bly 4 Unknown a autopsy tindings able prior to oletion of cause ath? Yas 2 No
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edical Certification: To Be Completed by Physician/Medical	Part II. Oth Hy St 25. Was c axami 1 2 Na 2 A 3 S 4 H	er significant condition of the conditio	al Hospital ng igation not be mined 28e. Ing Physician: Examiner: On	Dua Diabet Dua Diabet Dua It Inpatient Date of Injury (Month, Day Yeu Place of Injury - building, etc. (S)	osclerot to (or as a conse es to (or as a conse))	equence of): underlying ca ent 3 DO. of M street, tactory,	ausa giv	26. Place of De.	23b. Did 1	Yas 2 No s an autopsy ormed? Yas 2 No one) idence 6 Ott how Injury occu (Street and Numiwn, State)	3 Probei 24b. Were avalle comp of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	bly 4 Unknown a autopsy tindings able prior to oletion of cause ath? Yas 2 No Route Number, ed.
	Cause (D that initiat resulting in the r	er significant condition of the conditio	al Hospital ng igation not be mined 28e. Ing Physician: Examiner: On en	Dua Diabet Dua Diabet Dua Ig to death but no Data of Injury (Month, Day Yeu) Place of Injury building, etc. (S)	osclerot to (or as a conse es to (or as a conse))	equence of): underlying ca ent 3 DO. of M street, tactory,	ausa given	26. Place of De. 26. Place of De. 27. Place of De. 28. Place of De. 29. Place of De. 29. Place of De. 20. Place of	23b. Did 1	Yas 2 No s an autopsy ormed? Yas 2 No one) idence 6 Ott how Injury occu (Street and Numiwn, State)	3 Probei 24b. Were avallated and deep of dee 1 her (Specify) med ber or Rural France and due to the and due to the second and due	bly 4 Unknown a autopsy tindings able prior to oletion of cause ath? Yas 2 No Route Number, ed. he cause(s)
Completed by Physician/Medical	Cause (D that initiat resulting in the r	er significant condition death) Last er significant condition roke asa raferred to medical arr ass 2 No r of Death tutural 5 Pendia invasti deidant detam fiar 1 Certifyir k only 2 Medical	al Hospital ng igation not be mined 28e. Ing Physician: Examiner: On en	Dua Diabet Dua Diabet Dua Ig to death but no Data of Injury (Month, Day Yeu) Place of Injury building, etc. (S)	osclerot to (or as a conse es to (or as a conse))	equence of): underlying cat ent 3 DO of M street, tactory, ath occurred a investigation,	ausa given	26. Place of Deverors 26. Place of Deverors 4 Nursing H k? Yes 2 No ne, data and place pinion, death occur e number 2 4 2 2	23b. Dld 1	Yas 2 No s an autopsy ormed? Yas 2 No one) idence 6 Ott how injury occu (Street and Nummyn, State) cause(s) and my data and place, 29d. Date signe	3 Probe 24b. Were availate omy of de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	bly 4 Unknown a autopsy tindings able prior to oletion of cause ath? Yas 2 No Route Number, ed. he cause(s)



State of Maryland / Department of Health and Mental Hygiene 00 26769

					Cer	tificate	e of	Death			Reg. No.			
		1. Decedent's Name (First, Middla, Last)								2. Data of Death Month Day 2.2 Xear 3. Tima of Death				
1	Physician	James R. Kozuch								August 04, 2000 10:25pm				
	/Medical Examiner	4a Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death 4c. County of I						
		8025 Thornley Ct						Bethes	da	Montgom			mery	
	Funeral			M 2 F 7. Age (In yrs. last birthday) H Under 1 Y. Months D				If Under 24 Hours	Hrs.	8. Date of Birt (Month, Day	h Year)	9. Birthp). Birthplace (Stata or Foreign Country)	
П	or 28s-f show be notified at Director	1/5-30-0/58	f□ M 2□ F				Days	riours	WHIT.	Jan. 17,1938		Pennsylvania		
		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation			- 10			1	I Od. Inside City Limits	
		MD Montgomery Bethesda								Y⊕ Yas 2□ No				
		10e. Street and Number 10f. Zip Co.						de 10g. Citizen o				What Cour	ntry?	
		8025 Thornley Co		20817					USA					
	her death r heme 23 siner must Funeral	11. Marital Status	12. Was Deced	12. Was Decedent Ever in U,S. 13. W Armed Forces?			dent of h	lispanic Origin en, Mexican, P	? (Spec	cify Yes or No-	14. Rac	14. Race - American Indian, Black, White, etc.		
Maryland 21215-0020	Eran	1 Never Married 2 Amarried 3 Widowed 4 Divorced	1 ☐ Yas 2 If Yes, Give	1 ☐Yas 2 ☐ No If Yes, Give Year or Datas:		1 Yes 2 No Specify:				110211, 010.)	Specify: White			
	ed within 72 ho ygiene. er than "naturn t, the Medical. Completed	15. Decedent's (Specify only highest g	Education rada completed)	cation 16a. Dece		dent's Usual Occupation kind of work dona during most of working DO NOT usa ratired)				g	16b. Kind of Business/Industry			
	phone parties of the Man	Elementery/Secondary (0-12)		College (1-4or 5+)		dent, Reilly Mortga					Mortos	oe Ba	e Banking Co.	
d 2		17. Father's Name (First, Middla, La.		Ji tresid			18. Mother's Nen					0 0		
0	and the second s	Peter P. Kozuch									a Grabowski			
	should nd Men merks metho	19a. Informant's Name/Relationship			10h Mailin	on Address	/Street					Stata 7ir	Codal	
	高性申约	Dr. Donna Kozuch		Address (Street and Number or Rural Routs Thornley Ct, Bethesda										
	-2 E E V	20a. Method of Disposition	1-20.4	20b. Place of Disposition (Nama of cematery, crematory or other place)					Date		20c. Location - City or To		own, Stata	
	permit. Pages Department of Important: If his any injury or o ance.	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		tate	ional				กล	1100	Falls	Churc	h. VA	
H		21. Signature of Funeral Service Lic		Nac	7			on of Facility	-				11, 721	
ä		Joseph Gawler's Sons 5130 Wisconsin Ave, NW, Washington, DC 20016												
60		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximate Interval Between												
	Physician	Immediate Cause (Finel disease or condition resulting in death) Transitional cell Cancer of the bladder with Metastasis 4yrs Due to (or as a consequence of):												
	/Medical Examiner													
ı														
	a secuted in end ial-transit		b	Due to ter		wasse off.						i		
ć	certificate be assected adding physician end use as the burial-transit n/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury												
68760,	icate be physicials the burner edical													
99	ing ph as th	rasulting in death) Last												
Вох	attending pl for use as t		d								-			
ivision of Vital Records, P.O.	the atter thed for a	Part II. Other significant conditions confributing to death but not resulting in the underlying causa givan in Part I.								23b. Dfd tobacco use contribute to the cause of death?				
	d by detac								1 Yes 2 No 3 Probably 4 Unknown					
	5 5 G									24a Was	24a. Was an autopsy 24b. Were autopsy finding			
	70 (U) tom										rmed?	CC	vailable prior to ompletion of cause death?	
	has pe 2										•□"			
	certificate ha rector, page													
	ysician is certifi director	25. Was cese referred to medical examiner?	26. Place of Death (Check only one) Hospital: Other: Other:											
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	To the Hospital of within 24 hours at To the Funeral Discompletely filled is Completely filled is Medical Cel	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.												
	ithin 2 on the omple	one) and manner stated. ≥ 29b. Signatura apprints of certifier 29d. Date signed (Mo									ed (Month,	, Day, Year)		
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	10	Simplified MD 19858									August 11, 2000			
		30. Mame and addition of person who completed ceuse of deeth (Item 23a) (Type, Print) George Taler, MD, 110 Irving St. NW, Wahington D.C. 20010												
	State	31. Date filed (Month, Day, Year)		glsfrer's Signatu	-	1	0-	,						
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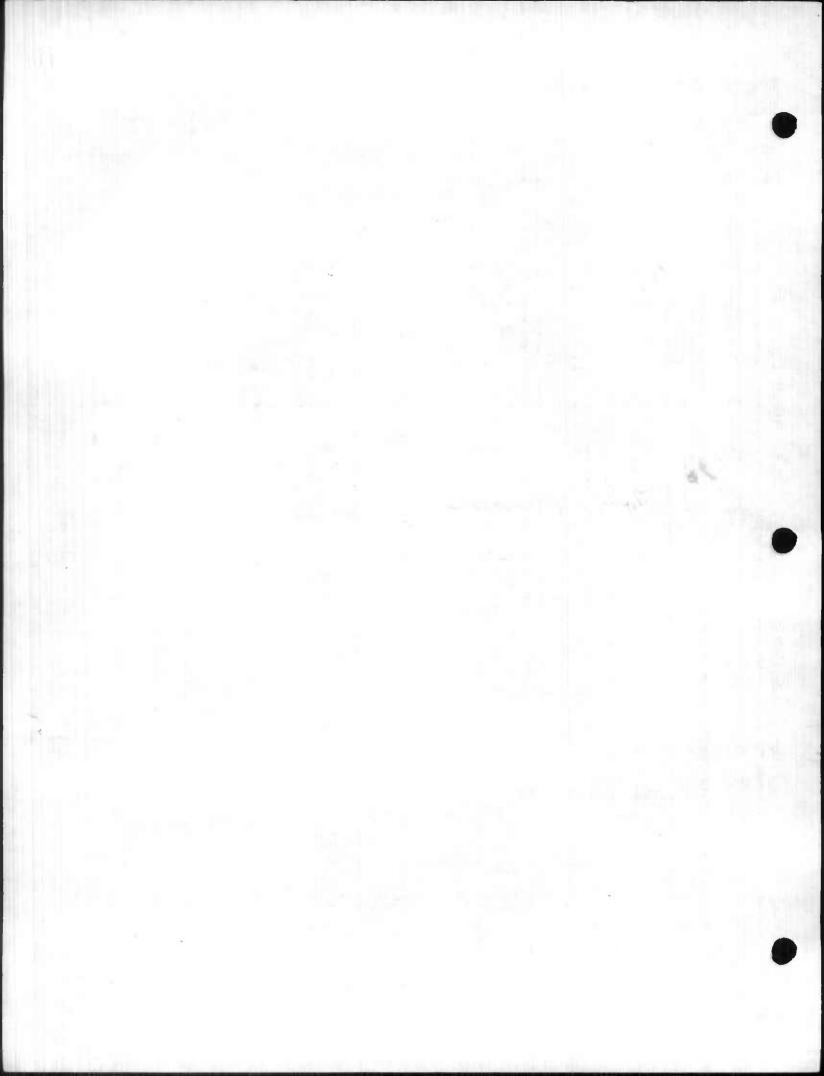


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 3, Nathan Kadan 2000 5:00am /Medical 4a Facility Name (tt not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. 6. Sex 1 → M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (tn yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Yrs Director 578 10 9740 March 1, 1913 (unknown) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 N Yes 2 No Director Montgomery Takoma Park 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? or flams 23s or mant be 611 Larch Ave. 20912 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Own Business 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) it. Pages 1 and 2 should be file
urtment of Health and Mertal Hy
ordant; if Nem 27 is marked oth
injury or other traumetic event Be Unknown Esther (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Bert Kadan 2844 Teramanto Dr. San Carlos, Cal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 8/5/00 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Services Stephen D. Lohrmann, PA 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) Vascular acc) /Medical Mon Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes 219 No 1 ☐ Yes 2 ☐ No certificate funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 Yes 2DNo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signatura d title of pertified 29c. License number 29d, Qate signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) Chevely M.O 20789 1 HOST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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		State of Ma	aryland			of Health and of Death	Mental Hy	rgiene	0	26772
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ician dical	Mary Ellen Kendı	rick					August	9, 2000) Yeer	5:20AM
niner	4e. Fecility Neme (If not institution, give	street end number)				4b. City, Town, o	or Location of Deet	h 4c. County	of Deeth	
	Collingswood Nu					Rockvil			gome	ry
at or	5. Social Security Number 6. S 578-84-1104	ex 7. Age □M 21X1 F	71	st birthdey) Yrs.	If Under 1 Y Months D	eer If Under 24 H ays Hours M	in. (Month, De	oy, Year) .0,1929	9. Birthp Coun Alat	plece (State or Foreign htry) Dama
tor	10e. Stata 10b. County Maryland Montgom	erv		Town or Loc					1	0d. fnside City Limits 1 ☐ Yes 2 🛣 No
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To Be Completed by	W. Dale Sheaffer-S					reat and Number or				Code)
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edical Examiner	Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in deeth) Last	b	Due to (or e	as e consequ as e consequ	ance of):					
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by Physician/M	Pert II. Other significant conditions of Parkinsons Dis-			ing in the und	derlying causa	a given in Pert i.		tobacco use cor Yes 2 No		the cause of death?
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o Be	25. Was case rafarrad to medical exeminar?	Hospital:				Other:	eeth (Check only o			
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edicai	29a. Certifier (Check only one) 1	sician: To the best of iner: On the basis of e end manner stete	exeminetion	edge, deeth o n end/or inve	occurred et the estigetion, in n	e time, dete and plea ny opinion, deeth occ	ce, and due to the curred at the time,	causa(s) and me data and plece, e	nner as stand due to	eted. the cause(s)
Me	29b. Signature and title of certifie	js				cense number		29d. Date signed		
	30. Name and address of parton who c				rint)	thesda, Ma				.000

State Registrar

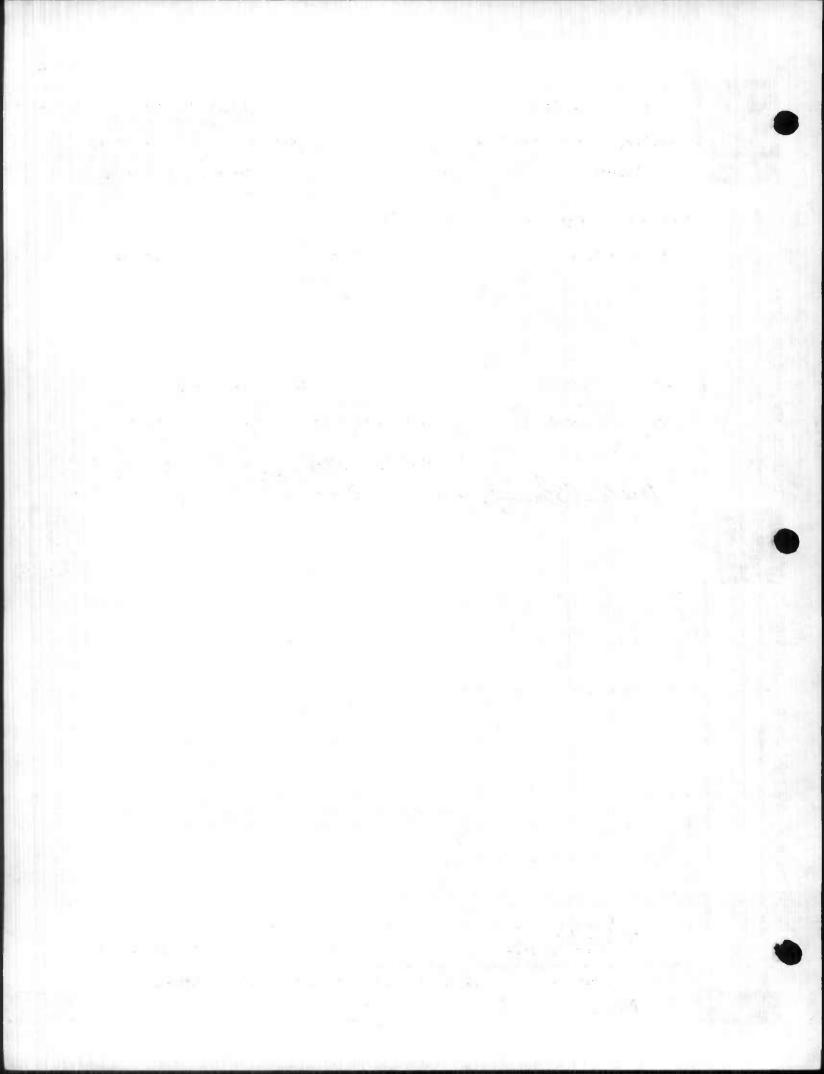
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

31. Dete filed (Mooth, Day, Year)

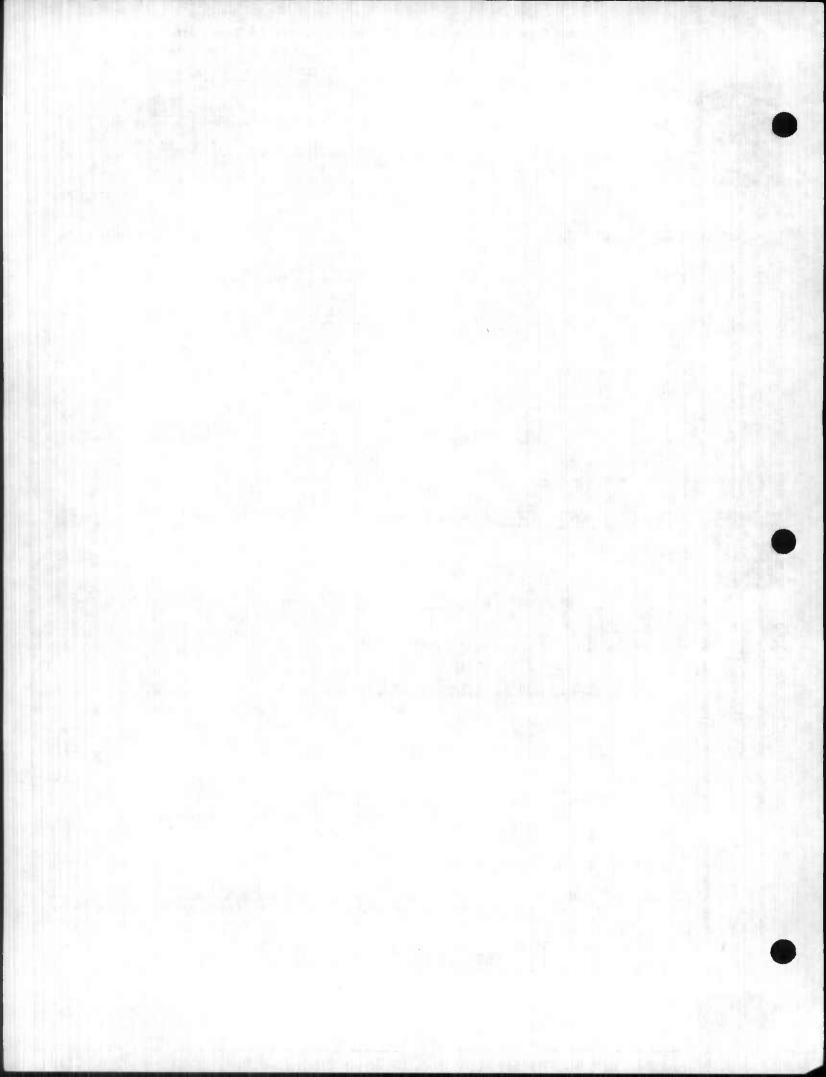
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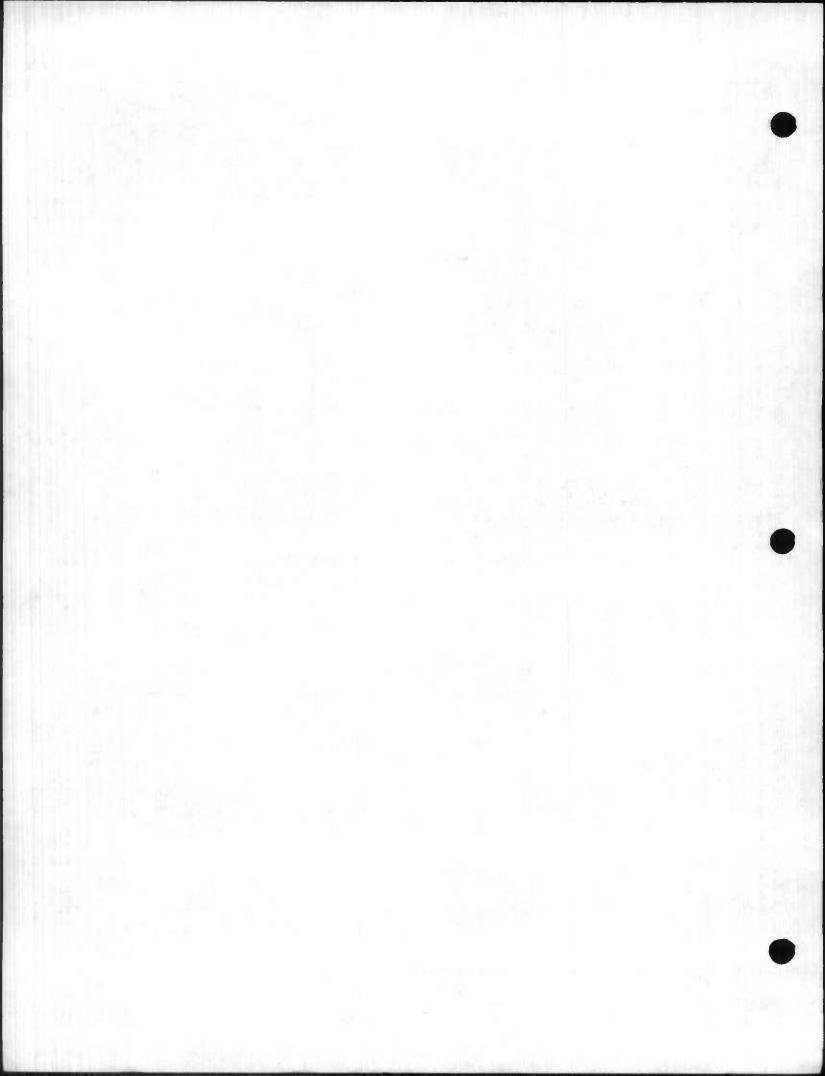


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				Certifica	ite of	Death			Reg. No.	1.1.		
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/Medical Examiner	to Contitle Manne (16 and innelle	tion, giva street end numb	per)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Death	1	
Lxammer	Holy Cross H	Hospital				Silve	er St	oring	Monts	omer	v	
	5. Social Security Number	, A	. Age (In yrs. last bi	irthday) If Und	ler 1 Yaar	If Undar		8. Data of Bir (Month, Da			ilaca (Stata or Fore	aion
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her death vertexes the state must	11. Marital Status	12. Was Deced	ant Ever in II S	13 Was Dec			nin? (Sne	orify Vas or No		e - Amaric	an Indian	
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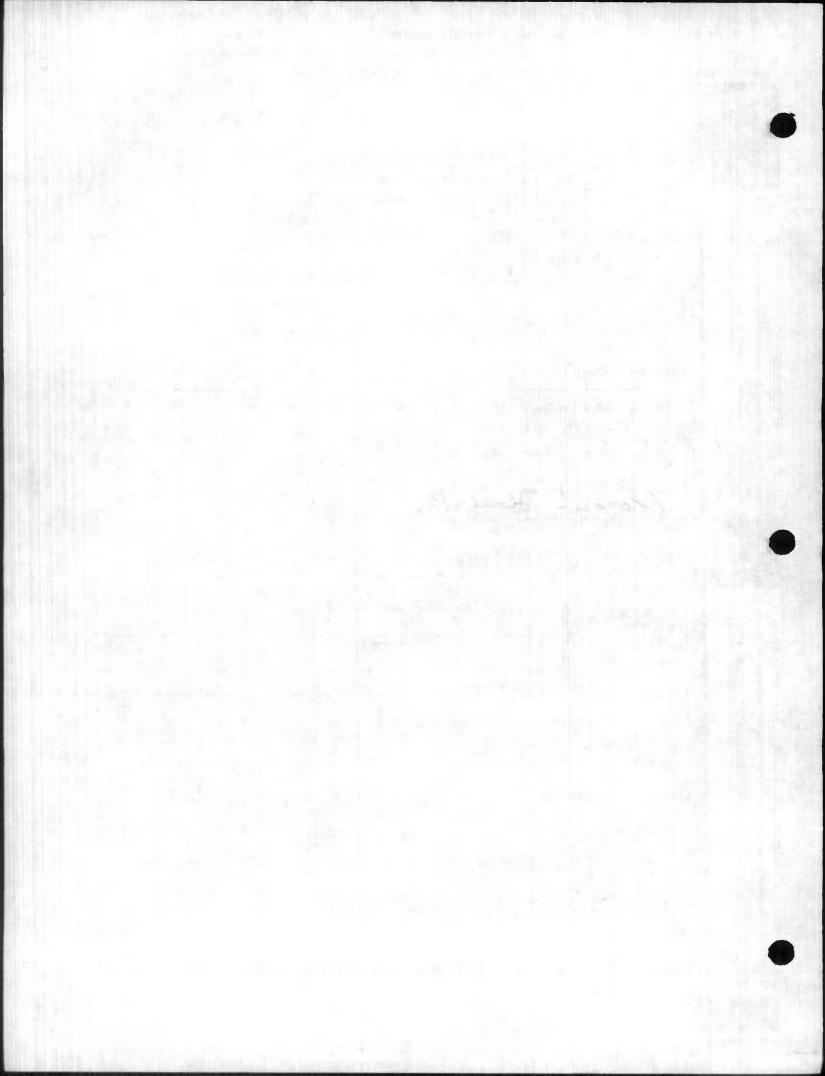


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n n	Her there	27. Manner of Death	28a. Date of In (Month, D		Time of Injury	28c. tnju Wo	ork?		28d. Describe	how injury occi	rred	
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	10	30. Name and address of person who		death (Item 22a)	(Type Print)	,					/	
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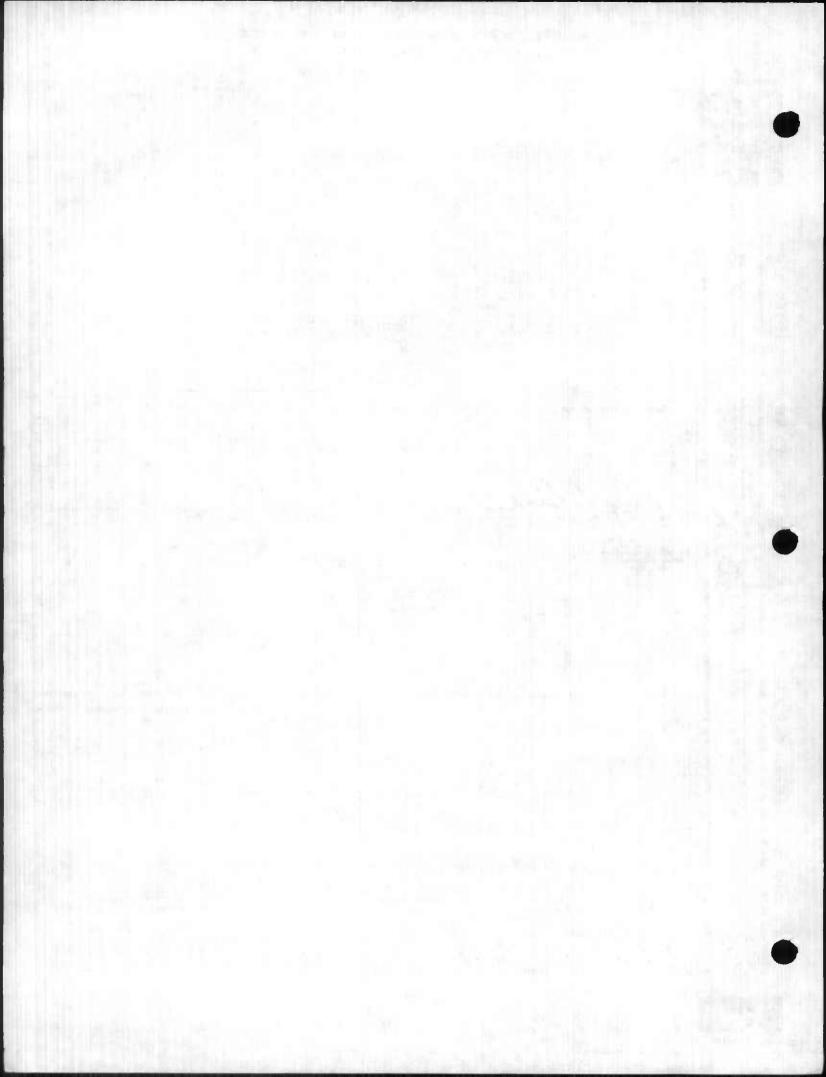


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Physician /Medical		11	Lucie	Korne	i			August	6	2000	4:00 P.M.
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	Amend Item	#18,Per Informant,G792			e of Death	R	eg. No.	20170
	Physician	Decedent'e Neme (First, Middle, La Dimitrios	Koskinas			2. Dete of Deat Month Augus	Dey	3. Time of Death 9000 10:40pm
	/Medical Examiner	4e Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	4c. County o	Deeth
	Funeral Director	Holy Cross Ho 5. Social Security Number 577-62-4311		ast birthdey) If Under Months	Silver : 1 Yeer If Under 24 Hra Days Hours Min.		Monto 5,1925	9. Birthplece (State or Foreign Country) Greece
	taryland state ed.st	Usuel Residence of Decedent 10a. State 10b. County Md Montgom		Town or Location	ng			10d. Inside City Limits P☐ Yes 2☐ No
	th with the Maryla 23s or 28s-1 sho ust be notified at rai Director	10e. Street and Number 2800 Gunarette	Way	10f, Zip	Code 20906	1	Og. Citizen of Wi	
020	ons after dea alt, or flams Examiner in by Funer	11. Merital Status 1 Never Married 20 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 Des 20 No If Yes, Give Yeer or Detes:	S. 13. Wes Deced	ent of Hispenic Origin? (S ify Cuben, Mexican, Puer No Specify:	pecify Yes or No- o Rican, etc.)	Bieck	- American Indian, , White, etc. White
and 21215-0020	ad within 72 ho ygiens. ar than "natur 4, the Medical. Completed	15. Decedent's E (Specify only highest gri Elementery/Secondary (0-12)		16a. Decedent's Usue (Give kind of wor life. DO NOT us Chauffe	ii Occupation k done during most of wo. e retired)		16b. Kind of Bus	liness/Industry Monetary Fund
/land	Mantal Hyg Mantal Hyg rhad other dic event, To Be C	17. Father's Neme (First, Middle, Last, Andrew Koski			18. Mother's Ne	me (First, Middle, I OLYMI a Greka	Maiden Sumame PIA KOSKI	NAS
, Mar	and 2 sho saith and n 27 is me we traum	19e. informent's Neme/Reletionship (Olympia Koskin	as/Daughter	2800 Gu		ay Silve	er Spri	ing, Md 20906
timore	mant of H	20a. Method of Disposition 1 Burial 2 Cremetion 3 C 4 Donetion 5 Other (Special	Removei from Stete Ga	tece of Disposition (Nemerotery, cremetory or o	ther place) Ven 8			Spring, Md.
Bal	Departiment important in any in	21. Signature of Funeral Service Licer	ald:	PHILIP 11818	d Address of Facility D.RINALD New Hampsh	nire Ave	e Silve	er Spring, Md.
X	Physician /Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	. Respirato			c or respiretory arr	0 st,	Approximate Intervel Between Onset end Death
-	hysician and the bural-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Postobstr Due to (or	uctive pn				2 1/2 wks
Box 68760,	ficate be physicial sthe bur edical	cause. Enter Undertying Cause (Diseese or injury thet initieted events resulting In death) Lest	C	es e consequenca of):	ll cell lı	ing can	cer	6 months
P.O.	by the achee	Pert tt. Other eignificant conditions of	contributing to death but not resu	ulting In the underlying c	ause given in Pert I.			tribute to the cause of death? 3\(\) Probably 4 \(\) Unknown
Records,	been sign should be					24e. Was a perfor	nn eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
	cate has					1 🗆 Y	es 2⊠No	1 ☐ Yes 2 ☐ No
of Vital	Physician: The this certificate ral director, pag. To Be Co.	25. Wes case referred to medical examiner? 1 Ves 210 No	Hospitel:	ER/Outpatient 3 DC	Other:	eth (Check only or dome 5 Resid		r (Specify)
_	ther this short in the state on:	27. Menner of Death 1 Neturei 5 Pending 2 Accident investigatio 3 Suicide 6 Could not by	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	8c. Injury et Work? 1 Yes 2 No	28d. Describe h	ow injury occurre	
Div	To the Heaptlal or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical Certificati	4 ☐ Homicide determined 29a. Certifier 1⊠ Certifying Ph	building, etc. (Specify,	")		City or Tow	n, State)	
	To the Hospital within 24 hours a To the Funeral Completely filled		niner: On the basis of examineti end menner steted.					
		29b. Signeture and title of certifier	. 1		License number	2		(Month, Dey, Year)
	10	30. Name end address of person who	Samelle	319	D35996		August	7, 2000
		Linda Burre			ity Blvd	4400 Si	lver S	pring.Md
	State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signet	ture A An	20 May	, 100		



State of Maryland / Department of Health and Mental Hygiene $\cap \cap$

					Certifica		Death		Reg. No.	1 20	1.1.1
	ician dical	Decedent's Nama (First, Middla, Las MELVIN	st)	LAWSON				2. Date of De Month 08	Day	Year	Time of Death 7:06 a.m.
	niner	4a Facility Name (It not Institution, give Prince George			r		4b. City, Town, or l Chever		,	of Death	ges
Funer Direct		370-30-7337	9x 7. A	ge (In yrs. lest bii 53	thday) If Unda Yrs. Months	Days		8. Date of Bir (Month, Do 10-07			(State or Foreign ct of Col
lend www.		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, Tow	n or Location					10d. lr	nsida City Limits
e Man	ctor	Md. Prince	Georges	Laur	el					Ď	☐ Yas 2 No
th with th	ai Director	10e. Street and Number 901 Fourth Stre	et			0 Coda 0 7 0 7			10g. Citizen of V		
d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. they than *naturel*, or items 23s or 28s-f show int, the Medical Experient must be not list at the death.	by Funeral	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Types 2 If Yes, Give Year or Detes:	?	13. Was Dece		Hispanic Origin? (Span, Mexican, Puert	pecify Yas or No o Rican, etc.)		e - American Inck, Whita, etc. Black	dien,
21215-0020 d within 72 hours aff piene. In then "naturel", or the wed selected.	Be Completed	15. Decedent's Ed (Specify only highest gre Elementary/Secondary (0-12) 1.2 t.h	ucation de com <i>pleted)</i> College (1-4or	16a 5+)	Decedent's Usu (Give kind of we life. DO NOT to Court		pation during most of wor ad)	orking 16b. Kind of Business/Industry Office			
E Staby	To Be Co	17. Father's Name (First, Middla, Last) Melvin Bernard	Lawson				18. Mother's Nan Eva E	ne (First, Middle Inora H		ne)	
Marylan d 2 should be the and Mental 7 is marked o treumetic eve	-	19a. Informant's Name/Relationship (7	ype, Print)	198			t end Number or Ru				
CTOL		Sharisse Lawso	on (Daugh		6487 Pe		ylvania A				
Pages ment of ant: If its ury or o		20a. Method of Disposition 1 🖾 Buriel 2 🗆 Cremation 3 🗆 4 🗆 Denation 5 🗆 Other (Specific		cemete	ry, cremetory or	other pla	s Cemeter	B -14-00	Chelten!	city or Town, s	
Balt permit Depart import	and a	21 Signature of Funeral Service Lean 232 Part Enter the disease, or comp thock, or heart feiture. List only	de	d the death. Do	Bacon	Fun	ess of Facility eral Home ing, such as cardiac	Was	hington	D. C.	
S8760, Medic Examined physicien and physicien and stree buriel-transit stree buriel-transit	al	immediate Ceuse (Final disease or condition resulting In daeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	D		consequence of)		DISEA VASCULA	rse R Dis	EXSE		at end Deeth
Box 68760, death certificate be executed e ettending physicien and of for use as the buriel-transit		Cause (Disaase or Injury that Initiated events resulting in death) Lest	d		consequence of)						
p.O. F. inet the dealed by the et	y Physician/M	Pert It. Other eigniffcant conditions of HYPERKALEMI	A		n the underlying	cause g	ivan in Part I.				cause of death?
I Records, P.O. The law requires that the state has been signed by the page 2 should be detached.	Completed by	MENTAL STA	TUS CH	LANGE					s an autopsy ormed?	eveitebl	utopsy findings e prior to tion of cause n?
	Com							10	Yes 2 No	1 □ Yas	2 No
of Vital I Physician: The Physician: The Physician: The Physician: The Physician	e B	25. Was case referred to medical examiner?	Hospital:			O	28. Piece of Dec				
Phys this rai di	J: To	27. Manner of Death	28e. Dete of Inj	ury 28b.	Time of	OA 28c. fnju	4 Unuising h		how Injury occur		
Vision Attending For death.	ation	1 Natural 5 Pending investigation		ey Year)	Injury M		Yes 2 No				
Division bal or Attending s after death. al Director: After ed in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At homa, farm, straet, factory, office building, etc. (Specify)							(Street and Numi wn, Stete)	ber or Rural Rou	ite Number,
Divisit To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physics Medical Example 1 Certifying Physics (Check only one)	ysician: To the best liner: On the basis of and manner s	of examination ar	e, death occurred ad/or investigation	et the t	ime, date and plece opinion, death occu	, end due to the rred at the time	cause(s) and m dete end place,	anner es steted end due to the	cause(a)
To the comp	M	29b. Signature and title of certifier	Alex		29c. License number 29d. Date signed (Month, Day, Year) D 00 52 865 8/1/2000				1011100		
(5)		30. Neme end address of person who of Dr. Michael Figa				1 Dr	. Cheve	rly, Md	20785		
	State	31. Dete filed (Month, Day, Year)	32. Regist	rar's Signature							

and the state of the state of the state of

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Nema (First, Middla, Last) 3. Time of Death Month **Physician** 3,2000 ROBERT PHILLIP LOCKHART AUGUST 8:35pm /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 817 DARIEN PLACE UPPER MARLBORO PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys 1X) M 2 F 235-54-2608 59 Yrs. 14,1940 ROBINETTE W. VA AUGUST Director Usual Residence of Decedant 10a. Stete 10c. City, Town or Location 10d. Inalde City Limits 10b. County 28a-f show 1 ☑ Yes 2 ☐ No MD PRINCE GEORGES UPPER MARLBORO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 238 817 DARIEN PLACE 20774 united states Funeral 12. Was Decedent Ever In U.S.
Armed Forces? 1 − sept
1 X Yas 2 □ No
If Yas, Give 31 − dec−8

1 □ Yes 2 ☒ No Specify:

1 □ Yes 2 ☒ No Specify: 14. Race - Amarican Indien. 11. Marital Status Black, Whita, etc. 1 Never Marriad 2 Merried 8 Baltimore, Maryland 21215-0020 BLACK Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Busineas/Industry Elementery/Secondery (0-12) College (1-4or 5+) INVENTORY MANAGEMENT SUPERVISOR U.S. AIR FORCE 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middla, Last) 1 and 2 should be Health and Mental CORNELIUS LOCKHART EFFIE LIMLY 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) . Nam 27 I DORIS A. CHRISTMAS-LOCKHART 817 DARIEN PLACE, UPPER MARLBORO, MD 20774 20b. Plece of Disposition (Neme of cematery, cremetory or other place) Dete 20c. Location - City or Town, Steta 20a. Method of Disposition Burial 2 Cremetion 3 Removel from Stete ARLINGTON NATIONAL CEMETERY 8-14-00 ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
ALEXANDER S. POPE FUNERAL HOME 21. Signeture of Funeral Service Licenses 2617 PENN.AVE S.E. WASHINGTON DC 20020 That caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, as on each line. Approximeta Intarval Between Onset end Death **Physician** /Medical Immediata Cause (Finel disease or condition resulting in death) Hypoxemia **Examiner** Due to (or es e consequence of) Examine Amyotrophic Lateral Sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in deeth) Lest Due to (or es a consequence of): certificate be execu Box 68760. Physician/Medical Dua to (or as a consequence of) the 88 980 0 P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yee 2 No 3 Probably 4 Unknown 3 should be det py Records. 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an eutopsy The law page 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 ☐ Yes 2 No Lo this 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending Investigation 1 Netural 1 Yes 2 No death. 2 Accident after deati Director: 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral completely filled Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a Certifier edical 29b. Signatura and title of certifie 29d. Date signed (Month, Dev. Year) 29c. Licanse number DUD DB 3318 August 7, 2000 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) John K. Kim, Capt, USAF, MC 1050 West perimeter Rd. Andrews AFB, Md. 20762

DHMH 16 Rev 6/95

State

Registrar

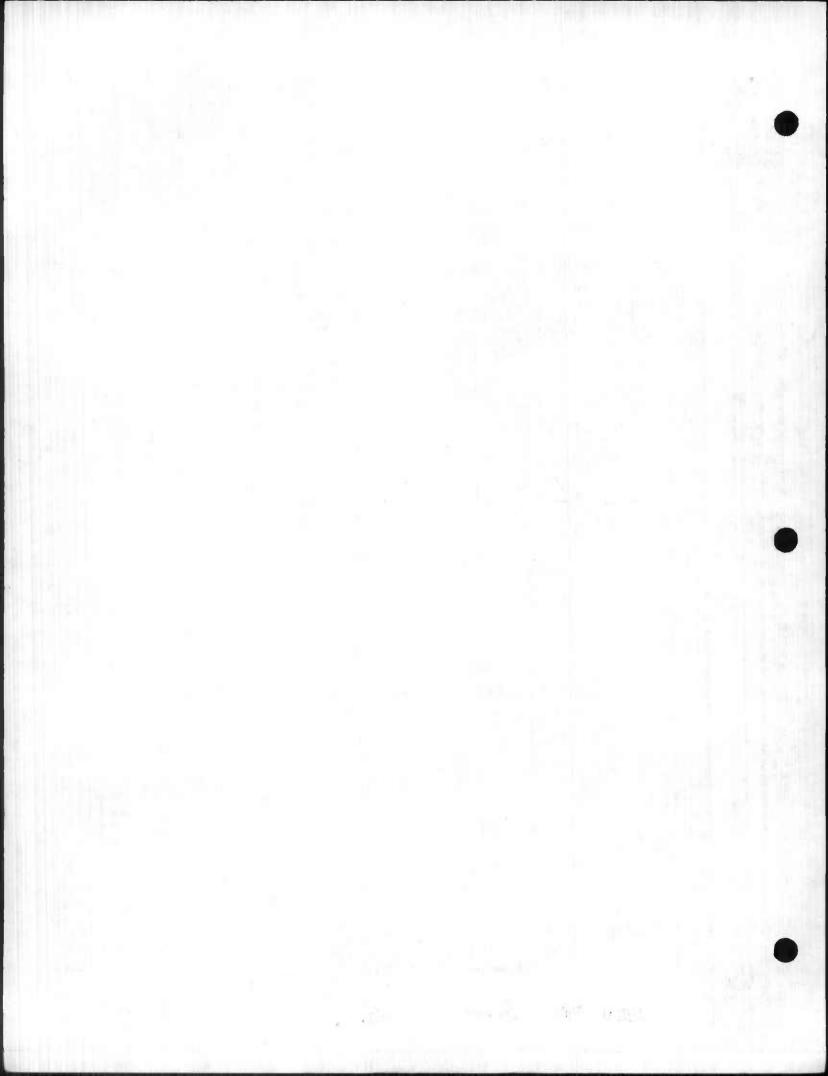
31. Dete filed (Month, Dey, Year)

AUG 0 9 2000

32 Registrar's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary		ertificate of		F	leg. No.	0 26779
п	Physician	Decedent's Name (First, Middle, I	_ast)				2. Data of Dea Month	Day	3. Tima of Death Year
	/Medical	Marion Lou:						7, 2000	7:05 am
	Examiner	4a Facility Nama (If not institution, g	ive street and number)			4b. City, Town, or Lo	cation of Death	4c. County of	of Death
1		Laurel Regional I	Hospital			Laurel			George's
	Funeral Director	577-20-7580	. Sex 1□ M 2☑ F 7. Age (In	yrs. last birthda Yrs.	Months Days		8. Data of Birth (Month, Day March 1	? Year) 2, 1903	9. Birthplaca (Stata or Foraign Country) Virginia
	ehow star	Usual Residence of Decedent 10a. Stata 10b. County	100	c. City, Town or	Location				10d. Inside City Limits
	or 28ed or Director	Maryland Howard		Laure	1				ty⊠Yas 2□ No
	or 2	10e. Street and Number			10f. Zip Code			log. Citizen of W	hat Country?
	23a	22 Center Street			20	723		U.S.A	
020	*netural', or farma 23a or 28e-f show deal Earther from D notified a steed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3XXWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2\S\No If Yes, Give Year or Dates:	in U,S.	3. Was Decedent of If Yes, specify Cut 1 ☐ Yas 2 ☐ No	Hispanic Origin? (Spoan, Mexican, Puarto Specify:	ecify Yas or No- Rican, atc.)		- Amancan Indian, , White, atc. White
Ö	netural fire	15. Decedent's		16a. De	cedent's Usual Occu	pation		16b. Kind of Bus	iness/Industry
Baltimore, Maryland 21215-0020	a 1 and 2 should be filled within 72 hos f Health and Mentel hyglane. Item 27 is marked other than "naturn other traumatic avant, the Medical To Be Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)		va kind of work dona . DO NOT use retin .emaker	during most of work ad)	ing	Own 1	Home
D	THE O	17. Father's Name (First, Middle, La.	st)			18. Mothar's Name	(First, Middle,		
lan	id be did	Louis Birch				Margare	- Madiso	n	
7	should ind Men unarke	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	niling Addrass (Stree	t and Number or Run			Stata. Zio Code)
M	d2 at the state of							20723	
6	ges 1 and 2 it of Health if Nem 27 I	Edith Watts - Day 20m. Method of Disposition			sposition (Nama of rematory or other pla	reet, Lau	Data Data		City or Town, State
ē		10 Burial 2 Cremation 3	Chemoval non same				111/00		
를	ortant: Perchant:	4 Donation 5 Other (Spec		ort Lin	coln Ceme		3/11/04	Brentwo	od, MD
Ba	pemil. Pege Depertment: Important: If eny injury or page.	I Signatura Service Co	mull	- /		neral Homo more Aven		tsville	, MD 20781
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ceused the	death. Do not	entar the moda of dy	ing, such as cardiac	or raspiratory and	ast,	Approximata Intarval Batween
	Physician		y one bases on base into						Onsat and Death
	/Medical	Immediate Cause (Final disease or condition	Rila	toral D	neumonia				2 days
	Examiner	resulting in death)		to (or as a cons					2 days
	خِ الساسا		D00	io (oi as a cons	sequence ory.				
	cate be executed physician and a the burdel-transit edical Examiner	Convention he had conditions	J b	to (or as a cons	sequence of):				
Č,	EX SET	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	500	10 (01 85 8 0015	oquerios ory.				
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89		resulting in death) Last	Due	o (or as a cons	equence or):				
Вох	Solling Solling		d						
ă	esth cartifi ettending i for usa as clan/Me								
o	ya the	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying causa g	iven in Part I.			tribute to the cause of death?
م	5 65 G	Chronic Atrial F	ibrillation,	Dehydra	tion		101	es 2 No	3 Probably 4 Unknown
ds,	5 0 D						24a. Was a	n autoneu	24b. Wara autopsy findings
Record	The law requires tate hes been sign page 2 should be Completed by	Control of the second					perfor		available prior to completion of cause
ec	hes bas pa 2 s								of death?
	The la						1 🗆 Y	as 20tNo	1 Yas 2 No
Vital	certificate rector, per	25. Was case referred to medical examiner?				26. Placa of Deat	n (Check only or	ne)	
5	2 00 5	1 ☐ Yes 2KDNo	Hospital:	2 ER/Outpat	ient 3LI DOA		ma 5□Rasid	ence 6 Otha	(Specify)
	After the funeral fune	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Data of Injury (Month, Day Yea	28b. Tima		ork?	28d. Dascribe h	ow injury occurre	d
0	Attending or death. ector: After tune by the fune liffication	2 ☐ Accident investigati	ion			Yas 2 No			
Division	tal or Attending P re effer death. el Director: After t ed in by the funen Certification:	3 Suicide 6 Could not detarmine		At homa, farm, pecify)	street, factory, office		281. Location (S City or Tow		r or Rural Routa Number,
0	A STATE OF THE STA								
	To the Hospital or Alte within 24 hours effer de To the Funerel Direct completely filled in by the Medical Certific	29a. Certifier to Certifying F (Check only one) 2 Medical Ext	Physician: To the best of my aminer: On the basis of axan and manner stated.	knowledge, de nination and/or	ath occurred at tha t invastigation, in my	ima, data and place, opinion, daath occuri	and dua to tha d ed at tha tima, d	ause(s) and mar lata and placa, a	nnar as stated. nd dua to tha cause(s)
	Within To the comp	29b. Signature and title of contine	AR O		29c. Licen	se number		29d. Data signed	(Month, Day, Year)
	6	1	the Co	M.	D247	21		A119115	t 7, 2000
	(12)	30. Name and address of person who	o completed cause of death	(Item 23a) (Tyn					,
	(1)	Syed A. Sadiq, 1				1. MD 20	708		
	State	31. Date filed (Month, Day, Year)	32/Registrar's S				, 00		
	Registrar	AUG 0 9 200	O Gran		South.	,			



State of Maryland / Department of Health and Mental Hygiene 00 26780

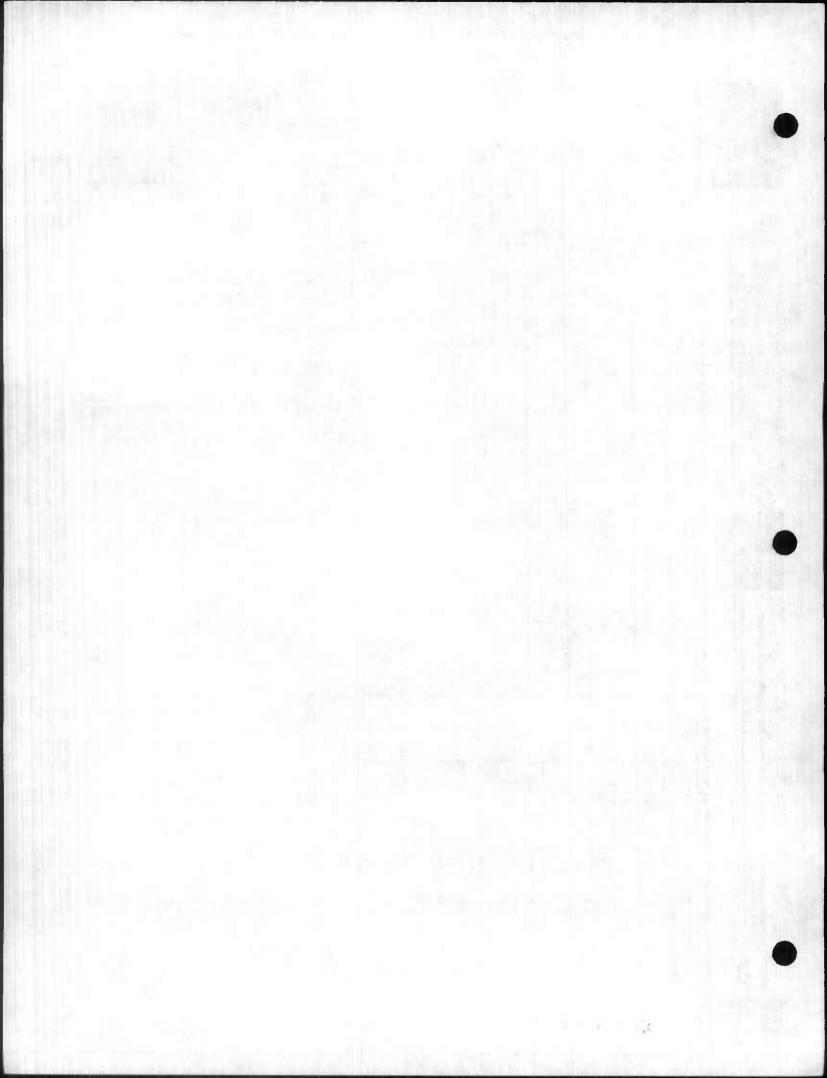
			Ce	ertificate of	Death	Re	g. No.	20100
	Dhomisis	1. Decedent's Nema (First, Middle, Last)				2. Date of Death Month		3. Time of Death
d	Physician /Medical	John C. La	ssiter			August	5 2000	9:45PM
	Examiner	4a Facility Neme (If not institution, give street and number 9603 Beachwood Ave.	er)		4b. City, Town, or Lo Seabro		4c. County of Des Prince	deorge's
	Funeral Director	089-03-2645 1№ 2□ F	Age (In yrs. last birthday, 88 Yrs.	Months Days		8. Date of Birth (Month, Day, May 28,	9. Bir 1912 No:	thplace (State or Foreign ountry) rth Carolina
	pu au	Usual Residence of Decedent 10a. Stete 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	vith the Maryli or 28a-f aho be notfilled at Director	New York		ew York				1 Nas 2 No
	after death with the Manylan or Items 23s or 28s-f show in the most be notified it.	10e. Street and Number 2235 - 5th Ave., #5F		10f. Zip Code	10037	10	g. Citizen of What C United	
020	5 E	11. Marital Status 1 □ Nevar Merried 2 □ Merried 1 □ Nevar Merried 2 □ Merried 1 □ Yes, Giva Year or Det	es? MNo	Was Decedent of I If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spian, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Bleck, Whi	
5-0	"netural",	15. Decedent's Education (Specify only highest grada completed)	16a. Dece	edent's Usual Occu	pation during most of work	ing 1	6b. Kind of Business	Andustry
2121	filed within 72 ho Hygiene. Wher than "neturn ent, the Medical ent, the Medical	Elementary/Secondery (0-12) College (1-4	tife.	Load	id)		Privat	e
Maryland 21215-0020	Be very	17. Father's Nema (First, Middla, Last)			18. Mother's Name Carr	ie B. Bu	eiden Sumeme) rden	
	d 2 sh th and 7 is m traum	19e. Informent's Neme/Reletionship (Type, Print) Carrie Miller - Sister			Terr., S			Zip Code) 20019
Baltimore,		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from St 4 ☐ Donation 5 ☐ Other (Specify)	ata	osition (Name of emetory or other plants of Cemete		Date 2:	Oc. Location - City or Flushi	
Balti	permit. Page Department of Important: If I eny Injury or page.	21. Signefure of Fymeral Service Licensee		22. Nama and Address		Stewart	Funeral H	
	Physician	23a. Pert1. Etter the diseese, or complications that caus shock of heert feilure. List only one ceuse on each	sed the death. Do not en h line.	nter the mode of dy	ing, such as cardiac (or respiratory arres	st,	Approximete Intervel Between Onset and Death
	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	Din to (or as e conse	equence of):				!
x 68760,	certificate be executed dding physician and usa as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last	Due to (or es a conse	cer_				
P.O. Box	d by the atter letached for the Physician	Part II. Other algnificant conditions contributing to deal	h but not rasuiting in the o	underlying cause gi	ven in Part I.		s 2 No 3 F	to the cause of death?
or Vital Records,	been sign should be					24a. Wes an perform		Were autopsy findings available prior to completion of cause of death?
ř	The lay page 2					1 ☐ Yes	s 280 No	1 ☐ Yes 2 ☐ No
E	certificate rector, pag	25. Was case referred to medical			26. Place of Deat	h (Check only one)	
	T die	examiner? 1		of 28c. Inju	iry at	me 5 Resider 28d. Describe how	nce 6 Other (Spow injury occurred	ecity)
Division	or Attendent deat Strector: in by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building	Injury - At home, farm, st etc. (Specify)		Yes 2 No	281. Location (Str. City or Town,	eet and Number or F Stete)	lural Route Number,
	Hospi 24 hou Funer taly fill	29a. Certifier (Check only 2 Medical Examiner; On the basi						
	To the comple	290. Signature and titlefor bertifier	in (ly)	29c. Licen	se number	29	August 8	th, Day, Year)
	(3)	30. Name and address of person who admipleted cause Frank B. Doggett, II	of death (Item 23a) (Type, I., M.D. 281	Print) 15 - 16th	St., N.E.	. Wash.,	D.C. 200	18
	State Registrar	31. Dete filed (Month, Dey, Year) ALIG 0 9 2009	istrer's Signeture	Some st.	,			

State of Maryland / Department of Health and Mental Hygiene

00 26781

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Edith 20 2000 August 12:00pm /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner | Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date | Months | Deys | Hours | Min. | Mo Mariner Health Care of Wheaton Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1 M 20 F Yrs. 71 March 23, 1929 West Virginia **Director** 286-24-6973 Usual Residence of Decedent r 25a-f show inotified at 10a, State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 TYes 2 No Directo Maryland Montgomery Silver Spring 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ĕ than "natural", or items 23s or the Medical Examiner must be 1220 East West Highway 20910 United States America Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Health Care Nurse 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 2 should be a section of marked of John Lee Ethel Bryant 19a. Informent'a Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hern 27 I epartment of Heal important if its any injury 1220 East West Highway Silver Spring Maryland 20910 Cindy Smith/Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriet 2 Coremetion 3 ☐ Removei from Stete 4 ☐ Donation / 5 ☐ Other (Specify) Fort Lincoln Crematory 8/7/2000 Brentwood, Maryland 22. Name and Address of Facility
Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood Maryland 20722 23e. Pe Li Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediete Cause (Finet diseese or condition resulting in deeth) /Medical Cardiac Arrhythmia 5 Minutes **Examiner** Due to (or as a consequence ot) Physician/Medical Examiner Chronic Renal Failure 6 Months The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) Box 68760, Due to (or es a consequence of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ≰RUnknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes an autopsy performed? page 2 should 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No of Vital To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation **©** Neturel 1 Yes 2 No 2 Accident 28l. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, atreet, lactory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) and menner steted. 29a. Certifier **dempletely** (Check only 29c. License number 29d. Date aigned (Month, Dey, Year) 29b. Signature and title of certifier Won 05-1714 August 4, 2000 JATINDER - S. SEKHON 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Blud #102 2401 Research Rockville. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 8 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5, 2000 4c. County of Death Florence B. Lipton 4b. City, Town, or Location of Death 1:10pm 4a Facility Name (If not institution, give street end number) Sandy Spring
| If Under 24 Hrs. | 8. Date Sharon Nursing Home Montgomery Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Dev. Year) Days 1□ M 2X F Months Hours Yrs. 143-03-6500 82 AUG. 28, 1917 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Nora Drive 20904 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Louis Boss Emma Meyerson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shelley K. Lemmond/ Daughter 1106 Nora Drive Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery 08/08/00 Woodbridge, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stein Hebrew Memorial Funeral H 232 Carroll St. NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause or each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final . ASPIRATION PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last ADVANCED ALZHEIMER'S DISEASE 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy 1 Vas 2 No 1 TYPS 2 NO 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

thet the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, 88 esn signed by the a page 2 certificeta Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifice funeral

Physician /Medical

Examiner

Examiner

Physician/Medical

Py

Be

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Certification:

edical

Physician

Examiner

Funeral

Director

th and Mental Hygiene. 7 is marked other than "naturel", or frame 23a or 28a-f ehov traumatic event, the Medical Examiner must be northed at

The first pages 1 and 2 should be filed within 72 hours after death with a partner of Health and Mental Hyglena.

Important: If them 27 is marked other than "not other traumatic."

the Menyland

/Medical

Directo

Be

29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier

ATTENDING PHYSICIAN

29c. License number

29d. Date signed (Month, Dey, Year) tugust 5, 2000

ddress of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HUFEMAN, M.D. 18100 SLADE SCHOOLROAD SANDY SPRING, MARYKAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rsv 6/95

To the Hosp within 24 hou To the Fune Complately fi

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2. Date of Death Month

August

04

3. Time of Death

10:04 AM

2000

29d. Date signed (Month, Dey, Year)

August 7, 2000

Examiner			4b. City, Town, or Location of Dee		4c. County		
		of Southern Ma		Clinton			e George's
Funeral Director	066-26-6959	Sex 7. Age (In yrs. 6			8. Dete of Birth (Month, Day, March 1	Year) 5,1932	9. Birthplace (State or Foreig Country) North Carolin
Maryland H show	Usual Residence of Decedent 10a. Stete 10b. County N • C • Pasquo	tank	. Town or Location	4			10d. Inside City Limit
72 hours after death with the Maryland natural; or frems 23a or 28a-f show deal Examiner must be notified at each by Funeral Director.	10e. Street and Number 803 South Road		10f. Zip Cod 279		10	g. Citizen of V	What Country?
at, or hems:	11. Maritel Stetus 1 ⅓ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	S. 13. Wes Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	Bled	e - American Indian, ck, White, etc. ··· Black
s 1.	15. Decedent's (Specify only highest g	Education trade completed) College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use rel	cupation ne during most of wor ired)	king 1	6b. Kind of Bu	usiness/Industry
Mental Hygiene. Mental Hygiene. Berked other than etic avent, the H	12th 17. Father's Name (First, Middle, Las		Nurse's Aid		ne (First, Middle, M	Priva Peiden Sumen	
Menta price To E	Joseph Lewis	Con Division	19b. Malling Address (Str.		Lewis	City on Town	Chata Zin Codel
f Health and Nem 27 Is ma other traum	19a. Informant's Name/Relationship Diane Matthews/	Daughter	10513 Fox La	ake Drive,	Mitchell	ville,	MD 20721
ant: If Ren ury or oth	20a. Method of Disposition 1 Buriel 2 Cremation 3 4 Donation 5 Other (Spec	MHemoval from State	lace of Disposition (Name of emetery, cremetory or other C Grove Cemete		08/09		City or Town, State th City, N.C.
by the attending physician and etached for use as the burial-transit property of the pure that the property of the pure that the property of the property of the pure that the property of the	23a. Part1. Enter the disease, or co- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	e. Myocardia Due to (o End Stage Due to (o Diabetes Due to (or	1 Infarction ras a consequence of): Renal Failur ras a consequence of):		or respiratory arre	st,	Approximate Interval Between Onset and Death
5 00 >	Part II. Other eignificant conditions Hypertension	contributing to death but not resu	ulting in the underlying ceuse	given in Part I.			ntribute to the cause of deat 3 □ Probably 4 ☑ Unkno
has been s ge 2 should mpleted					24a. Was ar perform	ned?	24b. Were autopsy findings aveilable prior to completion of cause of death?
Physician: The this certificate he ral director, page ral Corr.	25. Was case referred to medical examiner?	1			eth (Check only one		10165 2010
90	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ DOA	Other: 43 Nursing F	lome 5 Reside	nce 6 Oth	er (Specify)
in the Co	27. Manner of Death 1 ⊠Neturel 5 ☐ Pending 2 ☐ Accident investigati		Injury \	njury at Work? I Yes 2 No	28d. Describe ho		
الم المواد	3 Suicide 6 Could not 4 Homicide determine	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, street, factory, offi	Ce	281. Location (Str. City or Town		per or Rurel Route Number,
thin 24 hours e the Funeral I mpletely filled Medical Ce		Physician: To the best of my know aminer: On the basis of examinat and manner stated.					
Me aple	29b Signature and title of certifier		29c, Lic	ense number	29	d. Date slane	d (Month, Dey, Year)

31. Date filed (Month, Day, Year) State

1. Decedent'a Name (First, Middle, Last)

GERALDINE LEWIS

Physician

/Medical

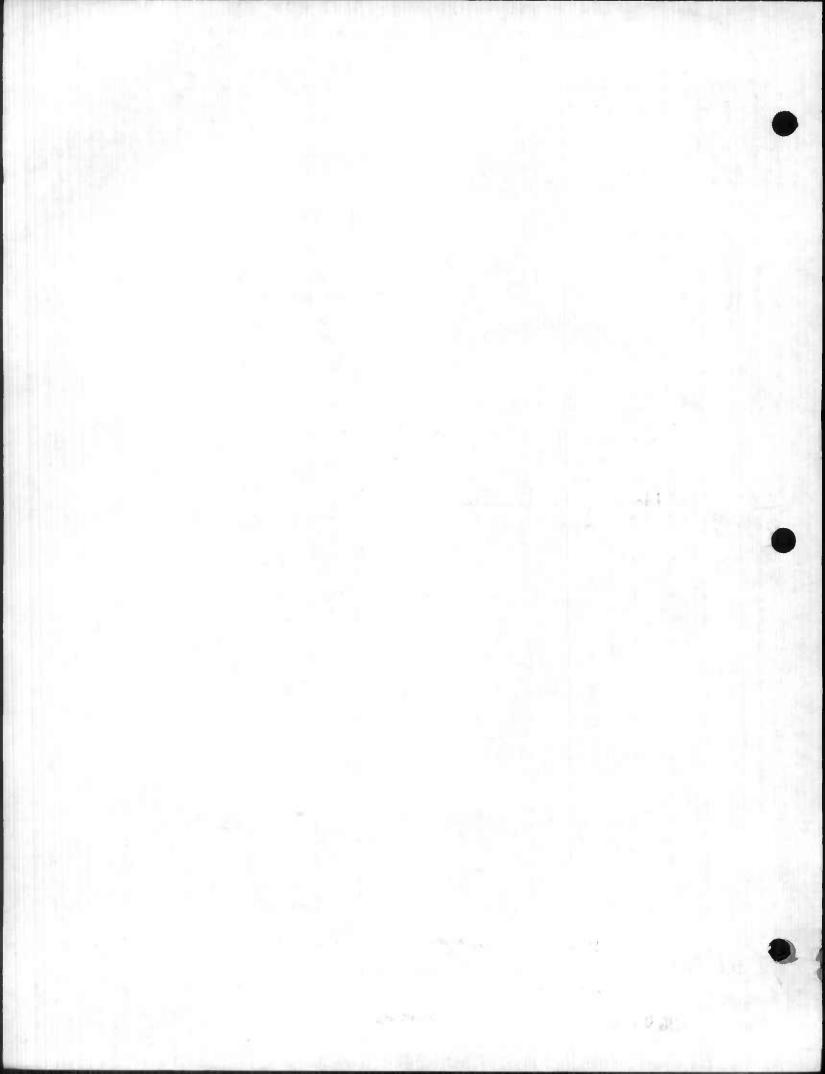
Khosorow Davachi, M.D., 1328 Southern Avenue, #310, S.E., Washington, D.C. 20032 32. Registrar's Signature AUG 0 7 2000

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

south

Registrar

025640

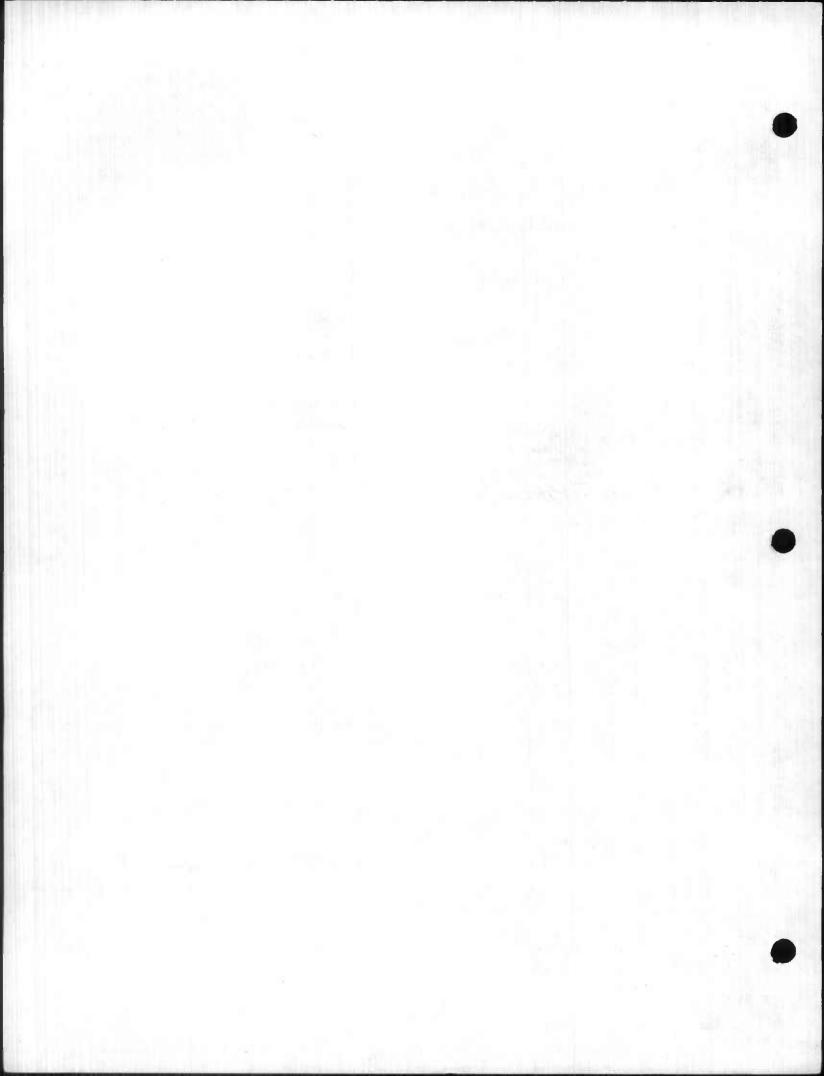


State of Maryland / Department of Health and Mental Hygiene 26784 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician August 2, 2000 1:30 AM Mildred M. Lancaster /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery Montgomery General Hospital If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Devs Hours 1□M 200 F Months 84 571-22-0908 Director January 17,1916 Minnesota Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiena. Interest if them 27 is marked other than "natural", or frems 23s or 28s4 show ary or other traumatic event, the Medical Exercises in the traumatic event, the Medical Exercises in the football. 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 International Drive 20906 Funeral United States 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: White à 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Interior Decorating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Martines Maude Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MaryAnne Harris/Friend 7604 Anamosa Way, Rockville, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 4, permit. Page Department of Important: If any Injury or once. Gate of Heaven Cemetery 2000 Silver Spring, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Lioung Rockville, Inc., 300 Rockville, Maryland Will EBour 700672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Sepsis 3 Days Examiner Due to (or as a consequence of): Examiner Metastatic Ovarian Cancer 3 Years physician and the burial-transit the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that influed executes.) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 80 980 signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4♥ Unknown Records. h The law requires 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation or Attending 1 (X Natural 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

• Funeral Director: A pletely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

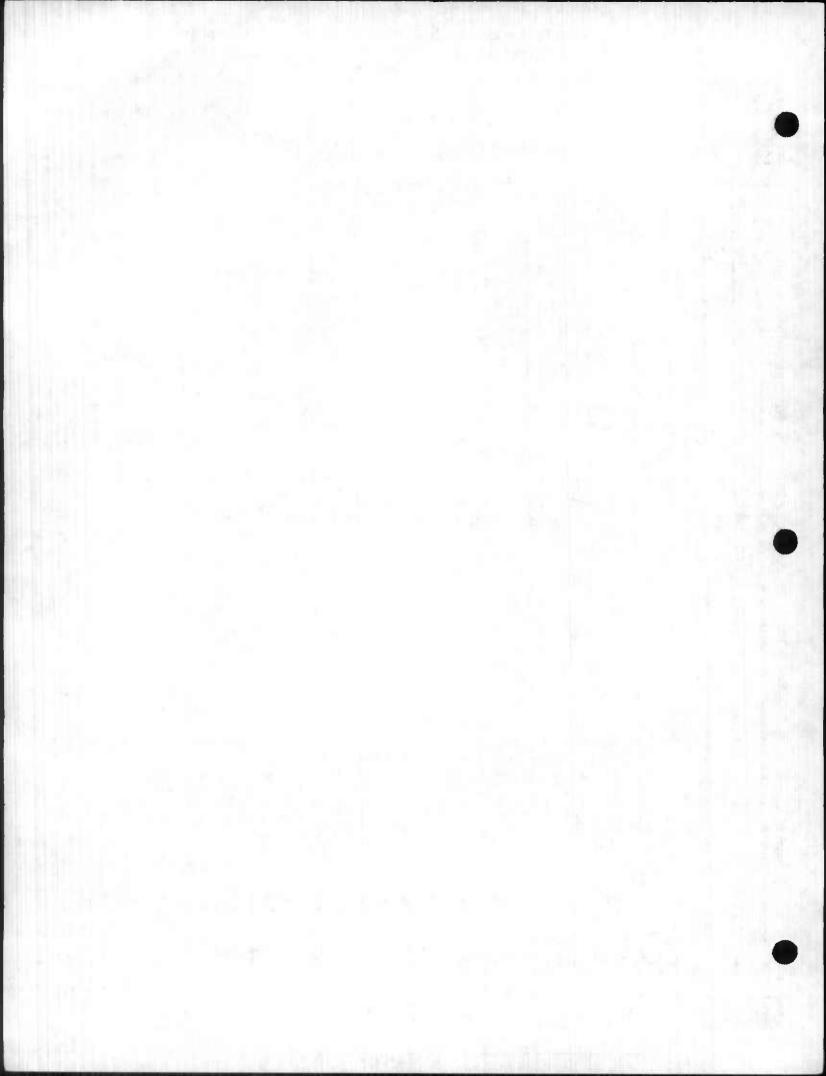
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end title of certitier 29c. License number 29d. Date signed (Month, Day, Year) D 46398 August 8, 2000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ghanshyam Gupta, M.D., 121 Congressional Lane, #409, Rockville, Maryland 20852 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State souls Registrar AUG 0 9 2000

DHMH 16 Ray 6/95



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	Certificate of Death								Reg. No.					
Physician (Madical	Maryareranne D. Large								2. Date of Do Month August	Dey	Year 2000	3. Time of Death		
/Medical Examiner	45 Facility Name (March Institution who standard number)							wn, or Lo	ocation of Dea					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.							8. Date of Bi (Month, D	rth ny, Year) 4, 1960	h 9. Birthpl (County)			
	Usual Residence of Decedent								White I	7, 1700	Wasii	ington, D.		
show sdat	10a. State 10b. County	10c. City, Tov	City, Town or Location								10d. Inside City Lin 1 ☐ Yes 2 🔀			
or 28s-fr	Maryland Montgo	nery	Montg	gome	ry Vi		ge			10g. Citizen of	What Cou	75		
ar, or hams 23a Examiner must by Funeral	9828 Hellingly P	lace		20886						United				
	11. Maritai Status	Ever in U,S.	13. V	Vas Dece			gin? (Sp	ecify Yes or N Rican, etc.)			can Indian,			
	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	Armed Forces 1 ☐ Yes 2 ☑ it Yes, Give Year or Dates:	No 1 ☐ Yes 2 🕅 No Specify:					Specify:			White			
ygiene. er then 'natur t, the Medical Completed	15. Decedent's (Specify only highest)	Education trade completed)	168	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)					ing	g 16b. Kind of Business/Indus				
mp less	Elementery/Secondery (0-12)	5+)	i+) life. DO NOT use retired) Manager							0 - 1 - 4 -	nking			
other of the Co	17. Father's Name (First, Middle, La	st)			Hai	lage		r's Name	e (First, Middle	, Maiden Suma		ig		
n and Mental Hy 7 is marked othe treumatic event.	John D. Large						Marg	gare	t B. Ba	rclift				
and	19a. Informant's Neme/Relationship	(Type, Print)	19	b. Mailin	g Address	(Street	and Numbe	r or Run	ai Route Numi	ber, City or Town	n, State, Zi	p Code)		
1 27 W	Margaret B. Large/Mother 407 Farragut Avenue,							, R						
Department of Health ar Important; if Item 27 Is any Injury or other trau ance.	20e. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Content of the Content								Date ugust 12, 2000	20c. Location - City or Town, S				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Rockville, Inc., 300 West Montgomery										y Fu	neral Hor		
	23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate													
/sician	shock, or heert tailure. List only one cause on each line. Interval Bet Onset and											Onset and Death		
Aedical aminer	Immediate Cause (Final disease or condition and disease or condition and disease or condition and death). Acute Myocardial Infarction										Minutes			
9.0	Due to (or es a consequence ot):									1				
n and ial-transit Examiner		b. Athero	sclerot			vaso	cular	Dis	ease		1	Years		
nal-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. Alcoholism											Vacana		
ding physician and se as the bunal-transit Medical Examir	Cause (Disease or injury that initiated events resulting In death) Last C. Alcoholism Due to (or as a consequence of):											Years		
use as		d												
the attenhed for u	Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.							23b. Dto	to the cause of de					
Ph Ph								1	3 Pro	obably 4K Unk				
should should			Marie Marie					24a. Was an autopsy performed?		a	Vere autopsy tindin vailable prior to ompletion of cause f death?			
page 2									1	Yes 2 No		☐ Yes 2☐ No		
certificate rector, par	25. Was case reterred to medical	26. Place of Deat					h (Check only	one)						
0 0	axaminer? 1 X Yes 2 □ No	Hospital: 1 Inpat	ient 2 ER/O	utpatien			4 LI NU	rsing Ho		idenca 8 🗆 O	-	ity)		
After the funeral fune	27. Menner ot Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	28a. Date of Injury (Month, Day Year) 28b. Time of Work? Injury M 1 Yes 2 No						28d. Describe					
1 5 E	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)					28f. Location (Street and Number or Rural Route City or Town, State)							
within 24 hours after dear To the Funeral Director: completely filled in by the Medical Certifical			the time, dete and placa, and due to the cause(s) and manner as stated. In my oplnion, deeth occurred at the time, date and placa, and due to the cause(s)											
To the comp	29b. Signature and title of certifier	101			29	c. Licens	e number			29d. Date sign	ned (Month	, Day, Year)		
10	30. Name and address of person wh	When	death (Item 23a)	(Type I	Print))3	69	70	1	auge	Lot	8,2000		
	Deharah Sh	will mo	9901	0.	4 1	cal	(60	tr	rpr.	Rock	0:11	< md. a		
State	31. Date tiled (Month, Day, Year)	-	rar's Signature	1	1				1			7		
Registrar	AUG 11 2	000 pen	was /	Ø.	popul	aks	1			.1 15				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent'e Neme (First, Middle, Last) Month **Physician** 0830 MILDRED LIUT BUGUST 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SURURAN HOSPITAL B878300 montgomaly H Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** BOSTON, MA 1□ M 2□ F Yrs. Director 465-48-2559 93 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County Yes 2□No MONTGCMERY N. BETHESDA Directo 10f. Zip Code 10g. Citizen of What Country? 10a Street and Number 8 mant be 5550 TUCKERMAN LANE 20852 U.S.A. 238 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Mental Status 1 Yes 2 No 1 Never Merried 2 Married 21215-0020 b Specify: WHITE 3 Widowed 4 □ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ages 1 and 2 should be fit ent of Health and Mental H till flasm 27 is marked oth y or other traumatic aven 2 SAMUEL SADAGURSKY LENA BREZINSKY 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MASON LILLY 11050 SEVEN HILL LANE, POTOMAC, MD 20854 SON Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete JUDEAN MEMORIAL GARDENS AUG. 8 2000 OLNEY, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetyre of Funeral Service License 22 Name and Address of Feeility EDWARD SAGEL FUNERAL DIRECTION, INC. Morald W. Kwensw 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** CONDESTIVE HEALT FAILURE /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of): AMTERIO SCIENATIC CANDIOVASCULAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown LF. HIP - INTERTROCHONTETIC FRANKT, ROWAL POILURE Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings CANCIDONA BROAT available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 28. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) Certification: 1 Natural
2 Accident 5 Pending tnjury SLIPPED IN GOOM 1 Yes 2 No investigation NUGUST 1, 2000 1200 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 5550 TUQKIN MA) CARS 28e. Place of Injury - At home, form, street, factory, office building, etc. (Specify)

NUNS & HONE (BLIGHTON GANDENS) 4 Homicide POTOMAC MO To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sig ature end title of certifier (OM5) N.D. 015236 AVOUT 4, 2000 P 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

CALL I. MAGGOLL, MO. 11125 POCKLILLE PIKE, POCKLILLE, MO 10852

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Dey, Year)

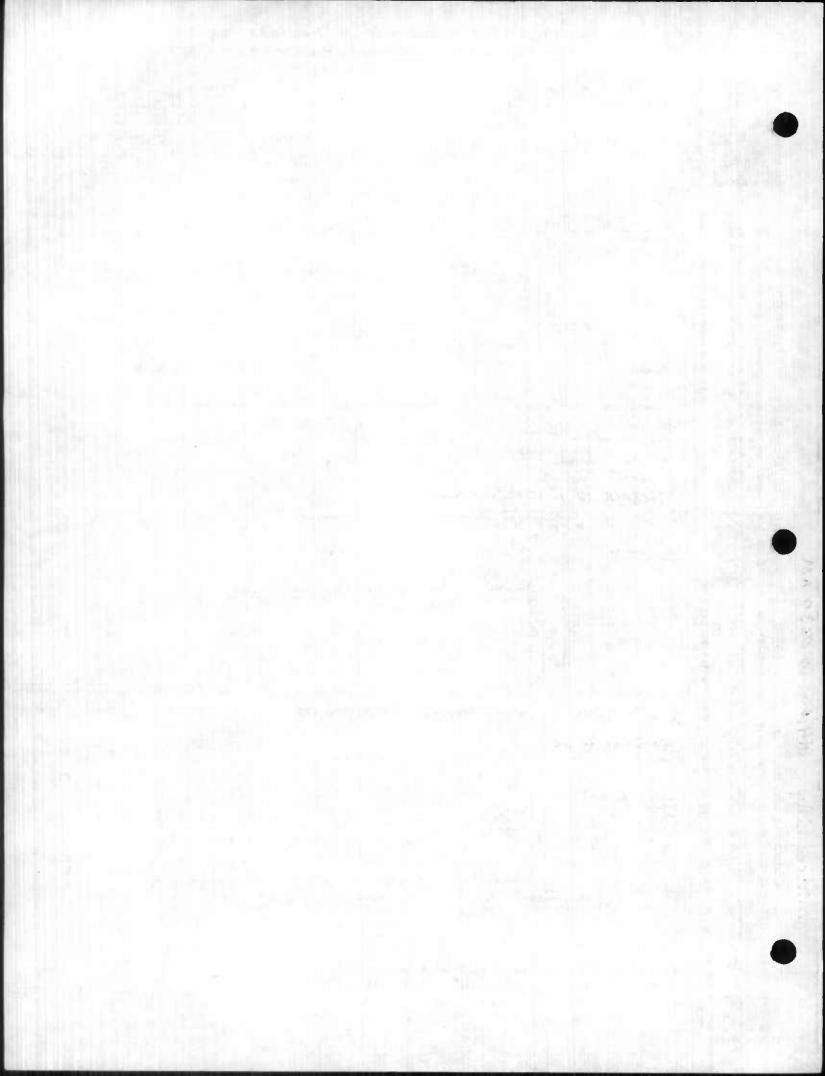
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32. Registrer's Signeture

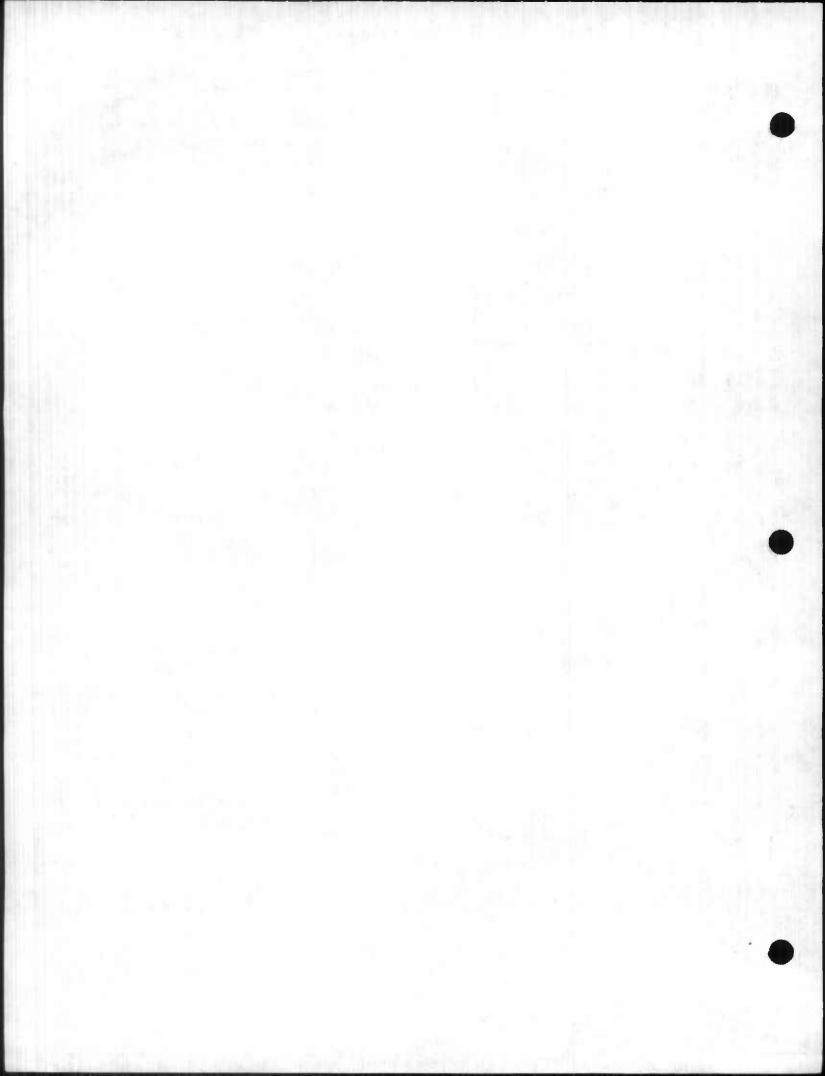


					Certific	ate of	Death		Reg. No.	6.00	0101		
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Las					2. Date of Dec		3. Tima of Death				
			.u				August		Year 000	7:30AM			
		4a Facility Name (If not institution, give				4b. City, Town, or L							
		8924 Falls Farm			. I Bille	nder 1 Year	Potoma If Under 24 Hrs.				3		
Maryland 21215-0020 of 2 should be fled within 72 hours after death with the Maryland ith and Mental Hygiene. 77 is marked other than "natural", or Nems 23s or 23s-1 show traumatic event, the Medical Exeminer must be notified at To Be Completed by Funeral Director	5. Social Security Number 6. St 219–92–0760	yrs. test birth	Mont	and the same of th	Hours Min.	8. Date of Birt (Month, De Aug. 3,	(State or F. Country) 3, 1926 9. Birthplace (State or F. Country) China						
	Usuel Residence of Decedent 10a. State 10b. County		10d. Inside City Limits										
	Maryland Montgome	ery	Potoma	ıc			1 ☐ Yes 2X No						
	10e. Street and Number			10f.	Zip Code			10g. Citizen of What Country?					
	8924 Falls Farm I	Orive			2085	4		United	Stat	es			
	11. Marital Status	in U,S.	13. Was De If Yes, s	ecedent of I specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	4. Race - American Indian, Black, White, etc.					
	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		1□ Ye	s 2⊠No	Specify:		Specity:	As	ian			
5	ed within 72 ho ygene. we then "neturn it, the Medical.] Completed	15. Decedent's Ed (Specify only highest gra	16a. (Decedent's U Give kind of	Jsual Occu work done	pation during most of work d)	ing	16b. Kind of Bu	siness/Ind	dustry			
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d 2		17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, Meiden Sumeme)					
lan	Mental H Mental H rhad off dic ever To Be	Wang Li-Min				(Not a	vailabl	vailable) Hou					
any	4DEE	19a. Informant's Name/Relationship (7	19b.	Mailing Add	ress (Stree	and Number or Rui	ral Route Numbe	er, City or Town,	Stete, Zip	Code)			
		Stephen Y. Liu/Son	n T	892	24 Fal	ls Fa	rm Drive,	Potoma	Potomac, Maryland 2085				
0 -116	一工 重音	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20c. Lo											
Balti	Departm Departm Imports any Inju	21. Signeture of Funeral Service Ucensee ROBERT A. Pumphrey Funeral Home/Rockville, Inc.											
		23a Part Fotor no disease or com		00198	Rocky	ille,	Maryland	20850	-2805		Approximate		
8	Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
/Medical	Immediate Cause (Final disease or condition Anaplastic Thyroid Carcinoma 22 months												
131	Examiner	disease or condition resulting in death) Anaplastic Thyroid Carcinoma Due to (or as a consequence of):											
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	tificate be assecuted up physician end as the bunal-trensit Aedical Examiner	Sequentially list conditions,											
60,	be ax	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	C										
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	the death cerry the attending sched for usa hysician/N	Part II Other elanificant conditions or	23h Did	23b. Did tobacco use contributs to the cause									
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Record	been shoul							24e. Was en autopsy performed? 24b. Were aut available completic of death?			ere autopsy findings allable prior to impletion of cause death?		
	The lew ate has page 2							10	Yes 2 No	10	∃Yes 2□No		
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of V	N S D	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Out	patient 3	DOA Ot	her: 4 Nursing H	ome 5 🖾 Resi	dence 6 Othe	er (Specif	y)		
	th. After this funeral a funeral	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Yea	ar) 28b. Ti	me of jury M	28c. Inju Wo	ry at ork?] Yes 2 □ No	28d. Describe	cribe how injury occurred				
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	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff		ysician: To the best of my siner: On the basis of exam and manner stated.										
	o the comple	29d. Date signed (Month, Dey, Year)		
	[0	James G. Proces MIL DO7285							August 1, 2000				
	(0	30. Name and address of person who o		(Item 23a) (1	Type, Print)								
		James A. Brown, M.				et, Ke	ensington	, Maryla	and 208	95			
	State	31. Date filed (Month, Dey, Year)	32. Registrar's S		1	bouls							
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State of Maryland / Department of Health and Mental Hygiene

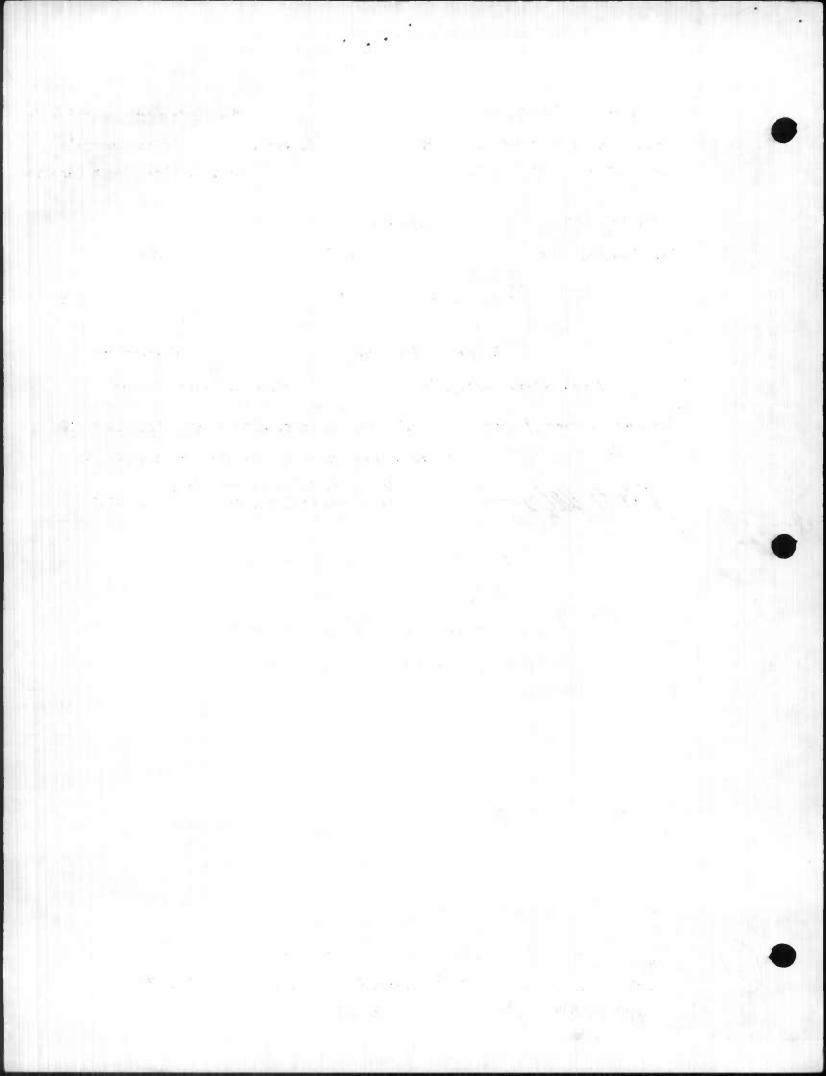
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/Medical	Alfred Lunking						b. City, To		cation of De	-	lc. County		7 .JJ AM	
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Funeral	5. Social Security Number	6. Sex 1 1 M 2 □ F	7. Age (In yrs. I		Months		Hours	Min.	8. Date of 8 (Month,			9. Birthp	place (State or Foreigntry)	
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4 6 M	10a. Stete 10b. County		10c. City	y, Town or Lo	cation							1	Od. Inside City Limit	
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r hams does my	1 Never Married 2 Mar	Armed F	Armed Forces? If Y			If Yes, specify Cuban, Mexican, Puerto Rican, etc					Biad	ck, White,	atc.	
hours after lursif, or its at Examine ad by Fu		If Yes. C	Give **		1 🗆 Yes	2₩ No	Specify:			Specify: (inese	
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and Market	19e. tnforment's Neme/Reletion	ship (Type, Print)		19b. Meili	9b. Meiling Address (Street and Number				al Route Nun	ber, City	or Town,	Code)		
and 2 saith a n 27 is er tras	Graham Lunking	/Son	8 Harvard Court					rt, Rockville, Marylan					d 20850	
-235	20e. Method of Disposition		20b. P	lece of Dispo	sition (Nar	ne of		1	Dete					
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The state of the s	4 Donation 5 Other (S		Mon	tgomery			-		2000	Bet	thesd	a, Ma	aryland	
MA POPUL	21 Signature of Funeral Service Lidenses 22. Name and Address of Fecility													
20122	M00846 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805													
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest. Approximate													
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/Medical														
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lal or Attending P is after death. In Director: After t ed in by the funer Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								281. Location (Street and Number or Rural Route Number, City or Town, State)					
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Hospital 24 hours Funeral stely filled		ng Physician: To the Examiner: On the												
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	one)		inner stated.	uorranio on III	- oungation	,iy (pinion, udi	, 000011		J, 3010 6	proce,	31.0 GUG (- 1.0 00000(8)	
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	100	1 Cu	u			Dag	367							
3	D20367 August 3,								3,	2000				
	Joel P. Kalman, M.D., 6111 Executive Blvd., Rockville, Maryland 20852-3976													
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State of Maryland / Department of Health and Mental Hygiene

						(Certifica	te of	Death		Reg. No.	0 2	0109
Physician	1.	Decedent's Name (Fir	st, Middle, Las	()						2. Dete of De Month	ath Day	Year	3. Time of Death
/Medical Examiner	40	James And Fecility Neme (If not							4b. City, Town, or L	August	5, 200 4c. County		10:00 P.M
Funeral Director	L	Prince Ge Social Security Number 224-60-651	6. Se	X 7.	Cent Age (In yrs 74		Month	er 1 Year S Deys	Cheverly If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, De Jan. 3	Princ y, Year) , 1926	9. Birthp	rge's lace (State or Foreign try) h Carolina
ahow Miles	-		County		10c. C	ity, Town	or Location					1	0d. Inside City Limits
rector	1	Virginia I	airfax			Alexa	ndria						1 ☐ Yes 2√ No
Je Je	-	De. Street end Number					1	ip Code			10g. Citizen of	What Cour	itry?
a a		6215 Houst	on Cour	t			2	2310			USA		
by Funeral Director	1	1. Maritel Status 1 Never Married 3 Widowed 4 1	2 Married Divorced	12. Was Deceder Armed Force 1 Ves 2 [If Yes, Give Year or Date:	s? ∃No 10/./	-46		edent of hecify Cub	Ilspanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No Ricen, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White, y:	
Completed by	-	15. I	Decedent's Edu	ucetion		16e. C	ecedent's Us	ual Occup	petion during most of world)	kina	16b. Kind of B	usiness/ind	dustry
nple	-	Elementary/Secondary		College (1-4d		-			d)				
S	-			4 3	rs	En	gineer			4000 - 4 41 4 41	Elect		S
Be	1	7. Father's Name (First,		drov. Mur		C			18. Mother's Nam				
2	-			drew Mur	lay,	1				ret The			0.41
	'	9a. Informant's Name/F							and Number or Ru				
	20	Margaret L		y/ Wife	20b.	Place of D	15 Hour	ston ame of	Court Al	exandri	a, Virg	inia Cltv or To	22310 wn. State
To	2	1 ☐ Buriel 2XXCre	metion 3 🗆 F										
	-	4 Donation 5 D			I ^v Ié	etrop			natory 8	3-7-00	Alexan	dria,	VA
be detached for use as the bunal-trensit and are by Physician/Medical Examiner	Si if co Ct the rec	mmediate Cause (Final isease or condition assulting in death) equentially list condition any, leading to immediate. Enter Underlying ause. Disease or Injuryat initiated events assulting in death) Lest	ι	a. Mu b. Arp c. Cirvl d. Coog	Due to (or as a co	insequence of the sequence of	1): P: E)	Foul typerte risdonx;	nni			
ysic	P	art II. Other significant	conditions co	ntributing to death	but not re	sulting in t	he underlying	cause gi	ven in Part I.				the cause of death?
y Pt										10	Yee 2 No	3 □ Pro	bebly 4 ☐ Unknown
Completed b										24e. Wes	en autopsy ormed?	av	ere autopsy findings alleble prior to mpletion of cause death?
o Be Comple										10	Yes 2 No	10	☐Yes 2☐ No
Be		5. Wes case referred to exeminer?	1100						26. Place of Dea	ath (Check only	one)		
ation: To	2	1 Yes 2 No 7. Menner of Death 1. Watural 5 [2 Accident	Pending Investigation			28b. Tir inj		28c. Inju Wo		ome 5 Resi	dence 6 Ott		(y)
edical Certification:		4 ☐ HomicIde	Could not be determined	building,	etc. (Spec	ify)				City or To	wn, State)		al Route Number,
completary filled in by the funeral director, Medical Certification: To Be (2	9a. Certifier XX (Check only one)	Certifying Phy Medical Exami	sician: To the be- iner: On the basis and menner	of examin	owledge, etion end/	deeth occurre or investigetion	d et the ti	me, date and place opinion, deeth occu	, and due to the rred at the time,	ceuse(s) end m date end place,	anner as a and due to	stated. the cause(s)
Me dwo	2	9b. Signeture end title o	of certifier				2	9c. Licens	se number		29d. Dete signi	ed (Month,	Day, Year)
)		1	-6	-		-		D	24535		2151	00	V
		D. Name and address o Laxmi N. 1. Date filed (Month, Da	Berwa,	M.D. 77	700 0	ld Br			Clinton,	Marylan	d 20735	- 0	
State Registrar	3	ALIG O		Se es	strar's Sign مراسم	H	Spa	Kal					



State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician 4:44A11 Morgan Denise Janet 2000 /Medical 4b. City, Town, or Location Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner HOPKINS JOHNS If Under 1 Year 7. Age (In 975 last birthday) 5. Social Security Number 8. Dete of Birth 9. Birthplace (State or Foreign **Funeral** 10 M 20XF Days Min. 250-17-4074 38 Yrs. November 9, 1961 Barberg, S.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-1 show 1X Yes 2 □ No Maryland Prince George's Upper Marlboro Directo the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 4323 Skipton Court United States Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ØNo If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Merital Status Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: Specify: Black py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Private Department of their and Schould be filed.
Department of their and Mental Hygher important: If them 27 is marked any injury or other in-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Cora Morgan 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 719 Peach Tree Place Columbia, SC 29210 Cora Morgan - Mother 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/10/2000 Landover, Maryland Harmony Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funerel Service Licen Stewart Funeral Home, Inc. 4001 Benning Road, N.E. Washington, D.C. 20019 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart tellure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Dulmonary 2 years Examiner Due to (or as e consequ Examine 20 years disorder TISSUE connective The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or es e consequence of) ate has been signed by the a page 2 should be deteched I Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate has 2 No 1 Yes or Attending Physicien: Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? after death.
I Director: After to in by the funers 1 Natural 2 Accident 5 Pending investigation injun 1 Yes 2 No 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and manner stated. edicai 29a. Certifier \$ 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 6, 2000 RES-000 elde MD 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Johns Hopkins Medical Hospital Heese Rosalyn

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

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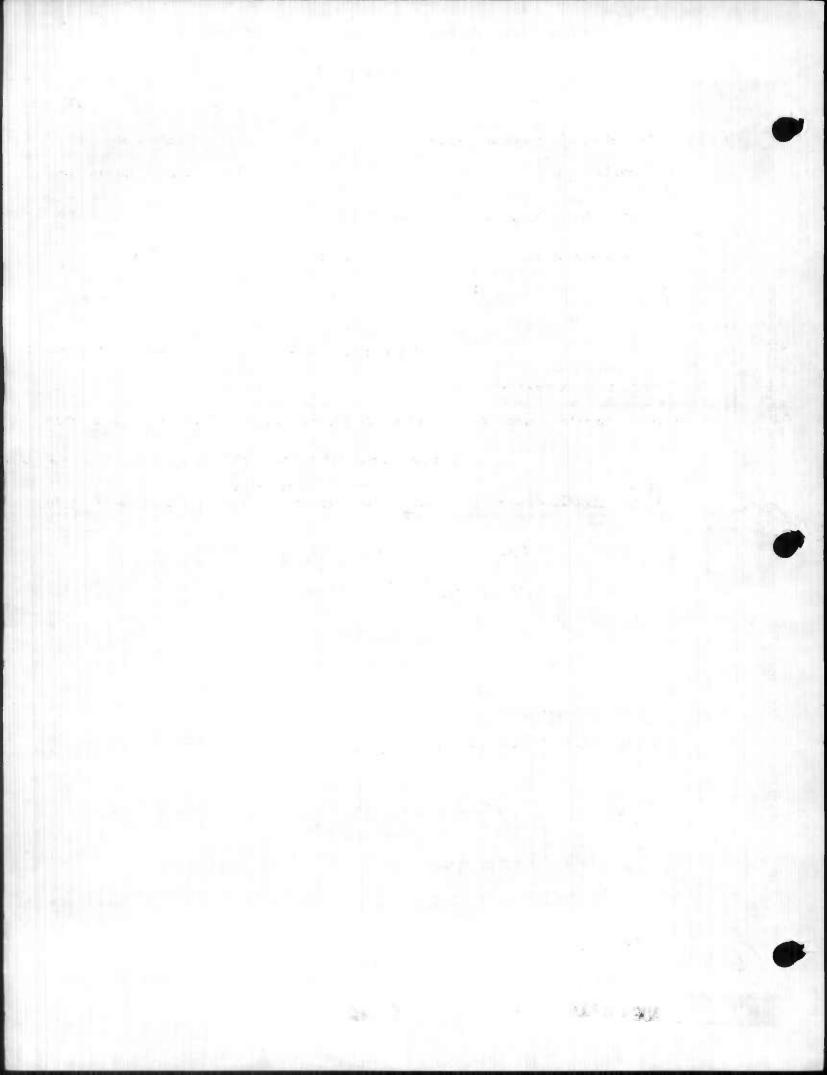
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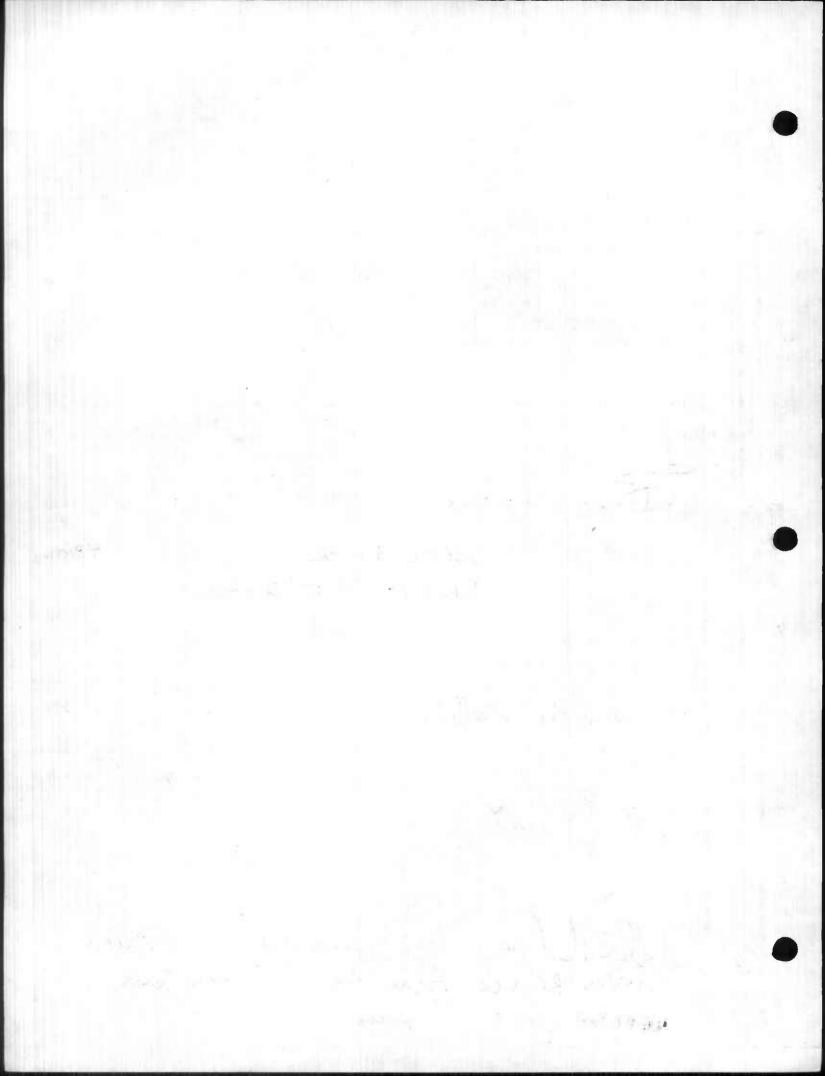
State of Maryland / Department of Health and Mental Hygiene

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			Certifi	cate of	Death		Re	g. No.			
1. Decedent's Name (First, Middle,						2	Dete of Deeth Month	Day	Year	3. Time of	
an Morgan Michael	l Mayolo						ugust 1			1:59	p.m.
4a Facility Neme (If not Institution,							tion of Death	4c. County			
Prince George'					Cheve			Prince			
5. Sociel Security Number 215-72-5317	6. Sex 7. A	ge (In yrs. lest b 41		Under 1 Year onths Days		Min.	Dete of Birth (Month, Dey, ept. 7,	Year) 1958 V	9. Birthpla Countr Vashit	ce (Stete or y) ngton,	.D.C.
Usuel Residence of Decedent 10a, Stata 10b, County		10c. City, To	um or Locatio	n					10	d. Inside Cit	by Limite
	e George's	100. Oily, 10	River							1⊠ Yes	
10e. Street end Number 5420 54th Avenu	ıe #5		1	of, Zip Code 207	37		10	g. Citizen of W		y?	
11. Merital Status 1 反 Never Merried 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedani Armed Forces	?	If Yas	Decedent of specify Cul	ben, Mexica	n, Puerto Rio	y Yas or No- can, etc.)		- America k, White, et	tc.	
15. Decedent' (Specify only highast		16	e. Decedent's	Usual Occu	ipation	st of working	1	6b. Kind of Bu	siness/indu	istry	
Elementery/Secondery (0-12)	College (1-4or		life. DO N			st of working 21		Constr	cuctio	on Ind	lustr
17. Fether's Name (First, Middle, L	Last)				18. Moth	er's Neme (/	First, Middle, M	leiden Sumem	Θ)		
Vincent Francis	s Mayolo				Mary	y Ann	Gallowa	ay			
19a. Informent's Neme/Reletionsh	hip (Type, Print)	19	b. Mailing A	dress (Stree	et end Numb	er or Rural F	Route Number,	City or Town,	State, Zip C	Code)	
Shawn C. Mayolo	- Brother	1	8600 N	W Tol	ovana	Stree	t, Port	land, (Orego	n 9722	29
20e. Method of Disposition 1 🖾 Buriel 2 🗆 Cremetion	2 DRamoval from State	cemet	of Disposition	y or other pl	есе)		Dete 2	Oc. Location -	City or Tow	m, Stete	
4 Donetion 5 Other (Sp		Lakem	ont Me	morial	L Gard	lens8/	7/2000	Davidso	onvill	le, MI)
Immediate Ceuse (Finel disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert II. Other eignificant condition Typerfens (1)	e. End st	Due to (or es e	r fevi e consequence e consequence	pe of):	tost					Onsat and D	
Pert II. Other significant condition		but not resulting	in tha undar	ying cause o	iven in Pert	i.		bacco usa cor	1/		
Itypertensi	om.						1 🗆 Ye	8 2□ No	3 Prob	ably 4□	Unknow
myocurdial	mfarct	ions	in p	ust			24a. Wes er perform	n eutopsy ned?	eva	re eutopsy f ileble prior to apletion of c eeth?	0
							1 ☐ Ye	s 2000	10	Yes 2□	No
25. Wes case referred to medical examiner?						e of Deeth (Check only on	8)			
1 ☐ Yes 2 No	Hospitel: 1 Inpat		-	LIDUA			5 Reside)	
27. Manne Deeth 1 Neturel 5 Pending 2 Accident investig		ey Year) 28b	Time of Injury	28c. Inj W 1 [uryet ork? ⊒Yes 2.⊑		d. Describe ho	w injury occurr	red		
3 Suicida 6 Could n 4 Homicide determi	ined 200. Place of It	njury - At home, etc. (Specify)	ferm, street,	fectory, offic	9	28	f. Location (St. City or Town		er or Rurel	Route Num	ber,
29a. Certifier 1 Certifying (Check only one)	g Physician: To the best Examiner: On the basis and manner s	of examination e	ge, deeth occ and/or Investi	urred at the gation, in my	time, deta a opinion, de	nd plece, an eth occurred	d due to the ce et the time, de	euse(s) end ma ete end plece, i	nner as sta and due to	ated. the cause(s	;)
1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending investig 3 Suicida 6 Could n determine 29a. Certifier (Check only one) 29b. Signeture and title of certifier				29c. Lica	nsa number		25	9d. Data signa	d (Month, E	Day, Year)	
> Wester	m			D43	662			8/1/2	000		
30. Name and address of person v WILLAM BOYCE 31. Data filed (Month, Day, Year)	3001 Ho	deeth (Item 23e	YT /- C	heverh	, MD	2078	T, P. C.	Hospi	tal		



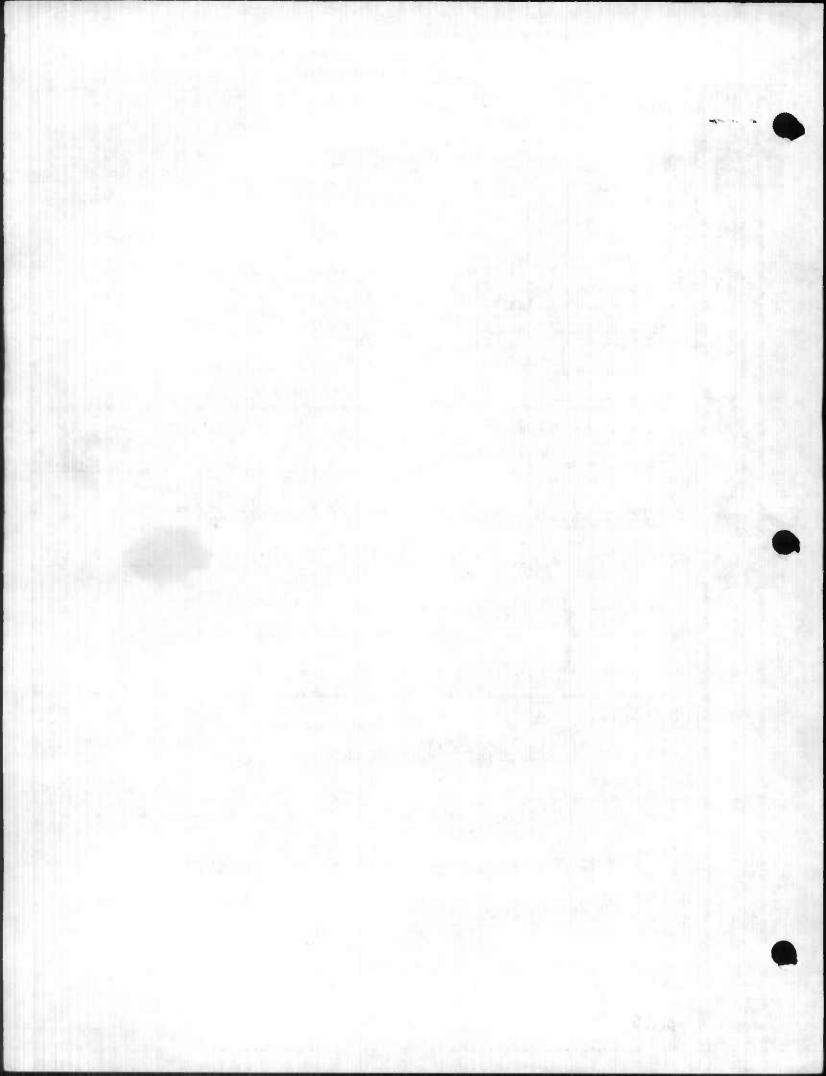
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 6, **Physician** 2000 12:03 P.M. Ruth Marie Mahorney /Medical 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Hunder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. September 17, 1930 County and Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1□M 20 F Months 578-38-2453 69 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Prince Georges Bowie 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? Нета 23а ог 12325 Flamingo Lane 20715 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Merital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 permit. Paper 1 and 2 should be filed within 72 hours aft permit and Health and Mental Hygiens. Important: If them 27 is marked other than "natural", or any injury or other traumatic event, the Medical Emeritant 1 Yes 2 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Nicholson Rena Rollins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Robin M. Schlorb / Daughter 12325 Flamingo Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery August 10, 2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Poneçal Service Licenses 3401 Bladensburg Rd. Brentwood, MD 20722 Doel that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, the on each line. **Physician** /Medical Immediete Cause (Final 48hour disease or condition resulting in death) Examiner Examiner TRACT INFECTION The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the buriel-tran Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Winknown been signed by 1 Yas 2 No à 90 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy this certificate has 2 KUNO 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifica filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Detienf edical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Datural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature/a d fitte of certif 29c. License number 12000 M 30. Name a ess of person who completed cause of death (Item 43a) (Type, Print) ever 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 8 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 11 26793

					Certifica	ate of	Death	Re	g. No.		_0/5	J
		1. Decedent's Nama (First, Mid	dle, Last)					2. Date of Deet Month		Yaer	3. Tima of E	Death
	Physician /Medical	MAUDE		McGHEE				August		000	12:15	AM
	Examiner	4a Facility Nama (If not Instituti	on, giva street and number	er)			4b. City, Town, or I	Location of Death	Death 4c. County of Death			
		Washington Ad	ventist Hos	pital			Takoma P	ark	Montg	omer	у	
	Funeral Director	5. Social Security Number 577–28–5344	6. Sex 7.	Age (In yrs. last I 84	Yrs. If Unc	der 1 Yaar Deys		8. Data of Birth (Month, Day, June 12	Year) 1916	Cour	placa (State or htry) h Carol	
	g ,	Usual Residence of Decedent		10: Ch. T-							04 6-14- 05	. 1.111-
	with the Marylar e or 28a-f show be notified at Director	10a. Stata 10b. Count			own or Location						l0d. Inside City 1 ☐ Yes	
	or 28a-f a be notified Director	D.C. N/A		Washi	ington						A	
	Dir.	10e. Street and Number			101.	Zip Code	20010	11	Og. Citizen of W		ntry?	
	ath we start	2232 Newton St					20018		U.S.A		can Indian,	
Maryland 21215-0020	urs shar death and or heme 23 Examinet man by Funeral	11. Merital Stetus 1 Never Married 2 Me 3 X Widowed 4 Divorce	If Yas Give	s? ⊒No X		cedent of I pecify Cub 2 X No	Hispanic Origin? (S ean, Mexican, Puart Specify:	pecify Yes or No- o Rican, atc.)	an, atc.) Bleck, White Specify: B1			
20	od within 72 ho yglene. wer then "hahum it, the Medical. Completed		nt's Education	16	Sa. Decedent's U	sual Occu	pation	tina	16b. Kind of Bu	sinass/în	dustry	
2	Med nple		ast grade completed) Collega (1-46	or 5+)			during most of wor	Arry				
2	Con the	Elementary/Secondery (0-12)		Но	ousewife				N/A			
Pu	Be every	17. Father's Neme (First, Middle	o, Last)				18. Mother's Nan	na (First, Middle, A	Aaiden Sumam	9)		
yla	Men Men	Bennie Lee Wi	mes				Moragn	e (Unkno	own)		E 20 (A)	
lar	2 and 2 and 3 and	19a. Informant's Name/Relation	ship (Type, Print)	15	9b. Mailing Addre	ess (Stree	t and Number or Ru	iral Route Number	City or Town,	State, Zip	Code)	
	and eaith ar t	JoSheryl McGhe	e - Daughte				Street N.					
Ore	T THE P	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 DRamoval from Sta		of Disposition (fitary, crematory of	Vame of or other pla	ica)	Date	20c. Location -	City or To	own, Steta	
E	Pag ment:	4 Donetion 5 Other			nony Mem	oria	Park	8-9-00 1	andove	r. Ma	arvland	
alt	THE STATE OF	21. Signeture of Funerel Service	Licensee		22. Name	end Addra	ass of Facility					
m	22-11	DOM:	D man	111			l's Funer			D.C. (20011	
		23a. P Enter the disaasa,	or complications that cause	sed the death. D	o not enter the m	oda of dy	ing, such as cardiac	or respiretory arre	ington.	DC	20011 Approximete	
	Physician	shock or near reliure. Lis	st only one cause on each	t iine.	1)					Onset end D	eath
	/Medical	Immediata Cause (Final disaasa or condition	FC	opha	god	C	ancer				Month	21
	Examiner	resulting In death)	a	Due to (or as	e consequance		0				4[071]	-
		THE N X TO EXT			0	,						
	ifficate be executed g physician and as the burial-transit ledical Examiner	Sequentially list conditions.	б.	Due to (or as	a consequence o	of):			-			
ó	an a	Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Causa (Disaase or Injury that Initiated events								i		
68760,	physicia s the bur edical	that initiated events rasulting in death) Last	C	Due to (or as	a consequanca o	of):						-
	E 0.0	resulting in Geath) East	d									3
Вох	The law requires that the death cert cale has been signed by the attendin page 2 should be detached for use Completed by Physician/M									1		
P.0.	the de ched	Part II. Other significant condit	1	n but not rasulting	In the underlyin	g cause gi	iven in Part I.		bacco use cor		A.	
۵.	hat the detail detail	Hy Deuten	ron					1 🗆 Y	ss 2 No	3 Pro	bebly	Inknown
ds,	sign d be	1111	111.11	1:00				24a. Was e	n autoney	24h W	era autopsy tie	ndinas
0	been si should	Atrial	fubrilb	1 TOY				partor	ned?	av	vailable prior to implation of ca	
3ec	has the e 2 a									of	death?	
F	Com							1 🗆 Ya	s 2000	1[Yes 2001	No
#	stan starting sector sector	25. Was casa referred to medic examiner?						ath (Check only on	Θ)			
5	T Sign	1 Yas 2 X No	Hospital: Inpu		Outpatient 3	DUA		lome 5 Reside			fy)	
Division of Vital Records,		27. Manner of Death		njury Day Year) 28b	D. Tima of Injury		ork? ☐ Yes 2 ☐ No	28d. Describe ho	ow Injury occurr	ed		
Sic	Attending or death. octor: After by the fune liftcation	2 Accident inves	tigation	1.1				28f, Location (St	wast and Alumb	or or Divi	of Courts Alumb	101
N	To the Hospital or Attendibility 24 to 12	4 Homicide deter	mined 200. Flace of	Injury - At home, etc. (Specify)	iam, street, leci	tory, office		City or Town	n, State)	er or muri	a) MODIO VUITE	w,
_	Hospital 14 hours Funeral tely filled IICal Ce	29a. Certifier Certify	les Physioles To the he	et of our boarded	on death conve	ad at the t	ina data and alassa	and due to the or			tated	
	in 24 house he Funer pletely fill edical	(Check only 2 Medics	ing Physician: To the be I Examiner: On the basis and manner	s of examination e	ge, death occurrend and/or investigati	ion, in my	opinion, daath occu	rred at the time, d	ate and placa,	and dua t	o the ceuse(s)	7.1
	ithin 2 To the comple	29b, Signetura and titla of certif		SIRIOU.		29c. Lican	se number	2	9d. Data signed	i (Month.	Dav. Year)	
	To To the	1.0	ally			04	2403		8 - 2	-2	000	
	(3)	W.			1.5	8 (10/					
	9	30. Name end address of perso	who completed cause of	daath (Itam 23s	(Typa, Print)	16	TOFFI	WAS	HINGI	ON	DC	200/
	.0	31. Data tiled (Month, Day, Yea) A 32 Regi	istrer's Signature	12011	/ /	(1000)	/				
	State Registrar	AUG 0 8 2000	Seren	9.	Soon st							
		HUG V O ZOOO	/		1							

DHMH 16 Ray 6/95



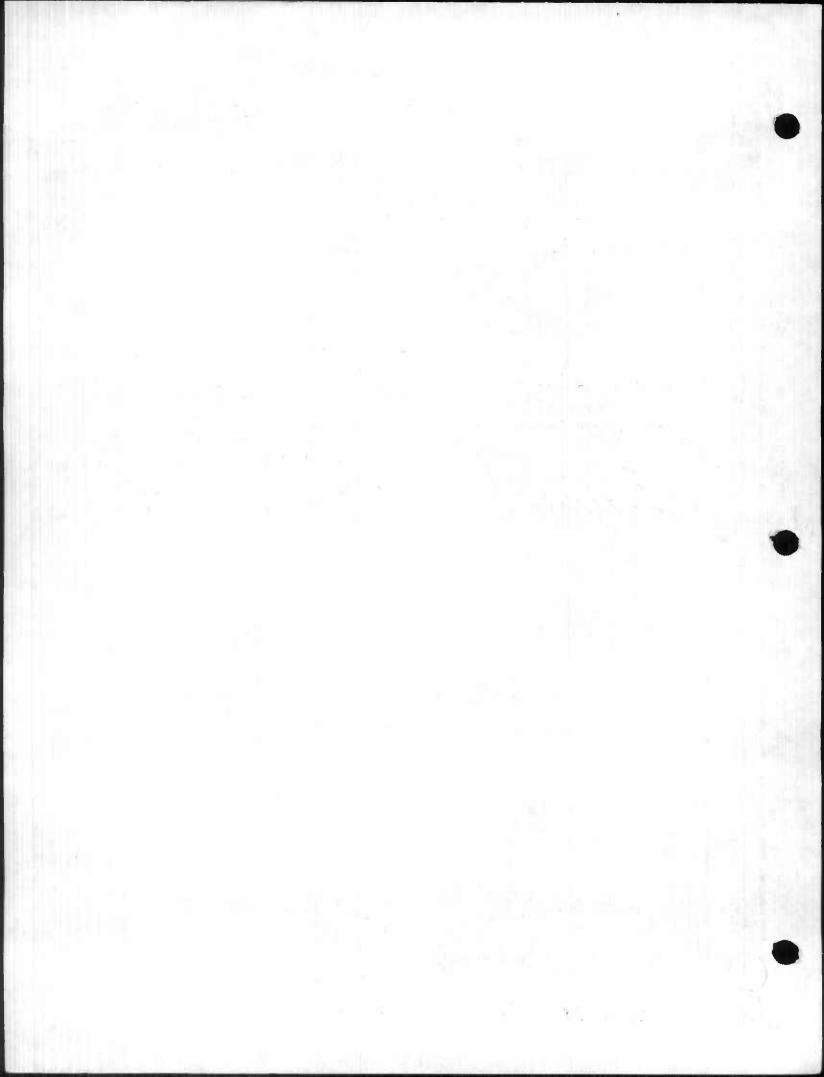
00-4599-033 JUANITA MYERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ASP AMEND ITEMSL: #23 PART I, Certificate of Death

26794

			Cert	ilicale of	Dealli	Reg). No.	
Physician /Medical	Decedent's Name (First, Middle, Last)	Juanita M.	Myers			2. Date of Death Month AUGUST		Yeer 2000 1711
Examiner	4a Facility Neme (If not institution, give s 12202 WINDER PI	street and number)			4b. City, Town, or L FORT WAS	ocation of Death SHINGTON	4c. County of PRINC	
Funeral Director		7. Age (In yrs. le		If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, 1 April 12	,1953 F	9. Birthplace (State or Foreign Country) Ota, Marianna I
2 *	Usual Residence of Decedent 10a. Stete 10b. County	10c City	Town or Loca	ation				10d. tnside City Limits
in ceath with the Maryla items 23s or 25s-f show ner must be notified at uneral Director	Maryland Prince Ge		t Wash:	ington			4	1 □ Yes 2 □ No
Dire Dire	10e. Street and Number 12202 Winder Place			10f. Zip Code 20744		10	g. Citizen of W USA	hat Country?
must must eral		12. Was Decedent Ever in U.S	13 W		Hispanic Origin? (Sp	ecity Yes or No-		- American tridish,
by Fun	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	lf '	Yes, specify Cub ☐ Yes 2 No	en, Mexican, Puerto Specify:	Rićan, etc.)		Asian
pet	15. Decedent's Educ (Specify only highest grade	cetion	16a. Decede	nt's Usual Occup	petion	ing	8b. Kind of Bus	siness/Industry
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)		NOT use retire	during most of work d)	1	Tolovic	sion Station
	17. Father's Neme (First, Middle, Last)	9	LACCUI	11/0 1133		e (First, Middle, M.		
o Be	Antonio Camacho A	talig			Anita De	la Cruz I	Manglon	a
-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing	Address (Street	and Number or Ru			
	Robert H. Myers/Hu		Same	as item	10			
	20e. Method of Disposition 1 □ Burial 2 □ Cremation 3 MR	emoval from States		tion (Name of atory or other pla	3			City or Town, Stete
***************************************	4 □ Donation 5 □ Other (Specify) 21. Signatur Funerel Service License		Geo.	Name end Addre	Kalas Fun	eral Home	e, P.A.	ianna Islands
1000	23a. Furt. Enter the disease or compliance, or heart failure. List only on	will.	616	O Oxon	Hill Rd.	Oxon Hill	I. Md.	20745 Approximate
Examiner Examiner	disease or condition resulting in death)	0	es a consequ					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events).	es e consequ					
etached for use as the but Physician/Medical	resulting in death) Last	Due to (or	es e conseque	ence of):				1
od for	Part It. Other significant conditions con	stributing to death but not resu	Iting in the und	derlying ceuse gi	ven in Part I.	23b. Did tob	acco uss con	tributs to the cause of death?
by Phys	ALCOHOLISM					1 □ Ye	8 2□ No	3 ☐ Probably 4 ☐ Unknown
2 should pleted						24a. Was an perform	autopsy ed?	24b. Were autopsy findings eveileble prior to completion of cause of death?
E O						1 D YYes	2 □ No	1 XYes 2□ No
Be	25. Was cese referred to medicel examiner?				26. Plece of Dea	th (Check only one)	
5	1 □XYes 2 □ No	fospitel: 1 Inpatient 2 E		3LI DUA				or (Specify) SCENE
tion:	27. Manner of Death 1 Natural 5 Pending investigation	(Month, Dey Year)	28b. Time of Injury UNKNOV	28c. tnju Wo	ryat ork? Yes 2 🕱 No	28d. Describe how		9 0
9 65	2 Accident Investigation 3 Suicide 6 X Could not be determined	Founds - 0 0 28e. Place of Injury - At ho building, etc. (Specify)				28f. Location (Str.	eet and Numbe	or Rural Route Number, 02 Winder P1
		sician: To the best of my knowner: On the basis of examineti	vledge, death o	occurred at the ti	ime, date and place,	P.G. Co	SUNTY , use(s) and mai	nner as stated.
completely fil	one)	and menner stated.	OH BITOOT HIVE					
E 00	29b. Signature end title of certifier	111.11	1	29c. Licen	.M.E		d. Dete signed UGUST	(Month, Day, Year)
)	30. Name and address of person who con	mpleted ceuse of deeth (Item	23a) (Type, P					16,2000
State	31. Dete filed (Month, Day, Year)	adent Z	ure #			Baltimore	, Mary.	land 21201
State Registrar	AUG 2 1 2000	S. Hegistrar's Signat	B. A	bout	/			

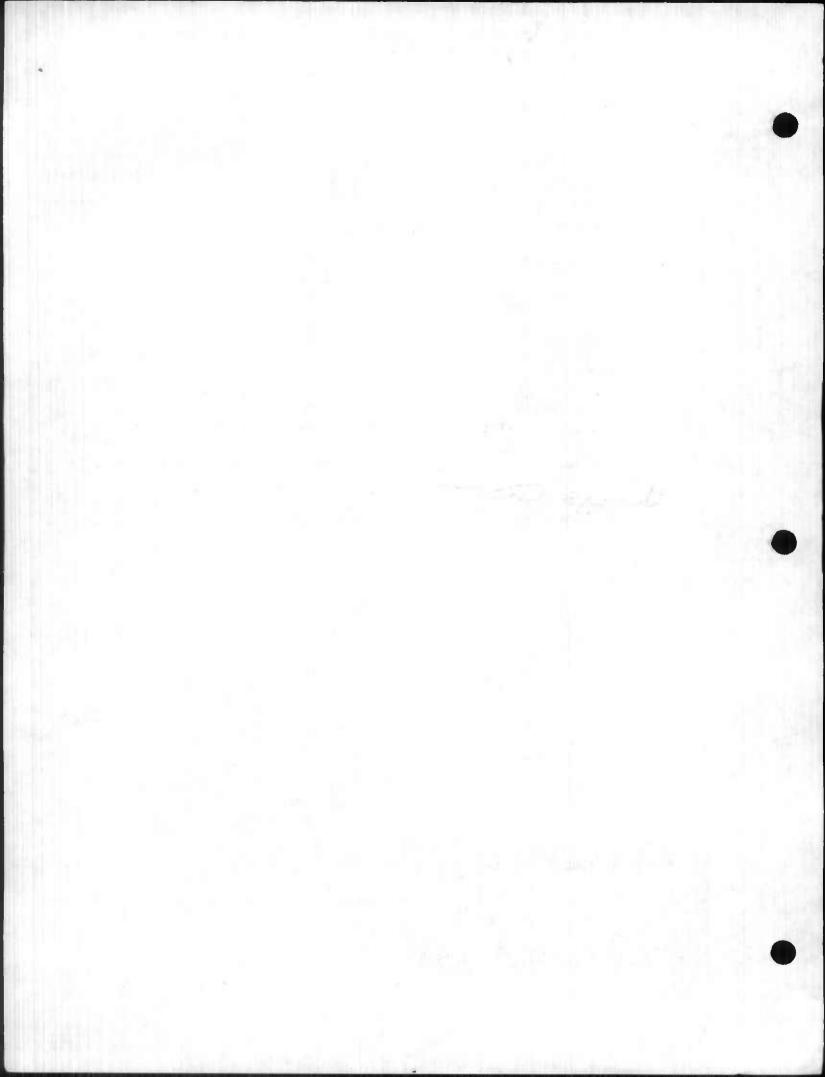


TRINGIAN TO	Q.	202 #23 E	PART I, 2	State of	Marylar	nd / Depar		Health and	Mental Hy	giene () ()	26795
	1		ne (First, Middle, L		PER M	<u>IEO - </u>			2. Date of De Month	ath	3. Time of Death
Physiciar /Medica	_	K	IRK I	ROBERT	MAN	LFOLD			AUG.	3, 2000	0010 AM
Examine	r 4		(If not institution, g HOSPITAL		iber)			4b. City, Town, or BALTIM		h 4c. County of	Deeth
Funeral Director		. Social Security P	Number 6.		7. Age (In yrs.	last birthday)48 Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs.	8. Dete of Bir (Month, De	ay, Year)	Birthplece (State or Foreign Country) ennsylvania
D		Isual Residença d 0a. State	10b. County		10c. C	ity, Town or Loca	ation				10d. Inside City Limits
with the Marylan a or 28a-f show be notified at		NJ	Cape Ma			Cape M					TX Yes 2□No
or 28a-f	1	0e. Streef and Nu		iy		Cape I	10f. Zip Code			10g. Citizen of Wha	at Country?
23a o		211 Je:	fferson S	treet			08204		19.0	U.S.A.	
y leans printern printern	oy runer	Marital Status Never Man Widowed	ried 2 Merried	12. Was Dece Armed For 1 Yes If Yes, Give Year or De	ces? 2 📉 No		es Decedent of Yes, specify Cut	Hispanic Origin? (Spen, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	14. Raca - Black, Specify:	American Indian, White, etc. White
72 hox		/Pno	15. Decedent's I			16a. Decede	nt's Usuel Occu	petion	dina	16b. Kind of Busin	ness/Industry
giene. re then 'r	Compilered	Elementery/Sec	ondary (0-12)	College (1-	4or 5+)		Plumbe	during most of worded)	King	Self-Emp	loyed
THOM O		7. Father's Name Robert	(First, Middle, Las E. Man	oifold					ne (First, Middle oeth M.	, Maiden Sumame) McGinni	S
2 should and Mer is merke			lame/Reletionship						ural Route Numb	er, City or Town, Sta	
of Health of Health if Item 27 or other tr		Oa. Method of Dis	• Manifolisposition Cremetion 3			Plece of Disposi cemetery, crema	fferson tion (Name of atory or other pla		Date Date	NJ 08204 20c. Location - Cit	
tant:		4 Donetion	5 Other (Spec	ify)		tional (08/06	Falls Chu	urch, VA
Depart Impor	2	21. Signature of F	uneral Service Lic	insee				ess of Fecility AWLER'S SC consin Ave			on, DC 20016
Physician		23a. Pert1. Enter shock, or he	the disease, or col art feilure. List onl	y one cause on ea	ich line.			ing, such es cerdia		errest,	Approximate Interval Between Onset and Death
/Medical Examiner	- 0	mmediate Ceuse diseese or condition resulting in deeth)	on	e	LCHOL	AND NAI	KCOLIC 1	INTOXICAT	TON		
ATTENDED !		osuking in dookin			Due to (or as e consequ	ence of):				
and transit	amine	Danier and lather tind		b	Due to (or es e consequ	ence of):				
and Carlot		Sequentially list of f any, leading to it cause. Enter Und	mmediete ertving		D00 10 (or es e consequ	ence orj.				
hysici the bu		Cause (Diseese of hat initiated event resulting in deeth)	r injury ts Last	C	Due to (or as a conseque	enca of):				
death certificate be ass e attending physician a of for use as the burial.	N N			d							
atten			After and a second second		- Ab 6 - A A A				non Did	Achana was analis	the state of the s
d by the	by rnys	ert II. Other signi	ificant conditions	contributing to de	ath out not re	sulang in the unc	denying ceuse g	ven in Part i.			Drobably 4 Unknown
o d d	Detec									s an autopsy ormed?	24b. Were sutopsy findings aveilable prior to completion of cause of death?
s been s 2 should									199	Yes 2□No	Yes 2 No
hes to		5. Wes case refe	rred to medical						eth (Check only	one)	
The law ate hes to page 2 s		examiner?	1 No			ER/Outpetient	3LI DON		·	idence 6 Other	
hysiolan: The law his certificate hes bal director, page 2 s	200	examiner? TYPES 2		28e. Dete o	n, Day Year)	28b. Time of Injury	28c. Inju	ork? ☐ Yes 2.10 No	UNKNC	how injury occurred	
hysiolan: The law his certificate hes bal director, page 2 s	200	N Yes 2☐ 7. Manner of Dee 1 ☐ Neturel	th 5 Pending	Found:		OTALGACAL		J.00 E2E.10			
A Attending Physician: The law flor death. Irector: After this certificate has to by the funeral director, page 2 sections.	200	↑ Yes 2 ☐ 7. Manner of Dee	th	Found:	JU of Johnson Add	nome, farm, afrec (fu) THER RES	et, fectory, office		BALTIN	(Street and Number MD State) MD	or Rural Route Number AVE
A Attending Physician: The law flor death. Irector: After this certificate has to by the funeral director, page 2 sections.		7. Manner of Dee 1 Neturel 2 Accident 3 Suicide	5 Pending investigeti 6 Could not determine	Found 8-2-(28e. Plece building	of Injury - At hig, etc. (Special Special Spec	THER RES	SIDENCE	time, date and place	a, and due to the	cause(s) and mann	
hysiolan: The law his certificate hes bal director, page 2 s		7. Yes 2 7. Manner of Dee 1 Neturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only	th 5 ☐ Pending Investigeti 6 ☐ Could not determine 1 ☐ Certifying P 2 ☐ Medical Exi	F 9 Month 28e. Piece buildin hysician: To the ba	of Injury - At hig, etc. (Special Special Spec	THER RES	DENCE occurred at the to estigation, in my	time, date and place	a, and due to the	cause(s) and mann	er as stated. d due to the cause(s)

State Registrar THEODORE MIK 31. Dete flied (Month, Day, Year) AUG 0 9 2000

82. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 2145 Carla Mason 4 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Death **Examiner** Cheverly Prince Georges Prince Hospital Center 6-corges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 1, 1942 If Under 1 Year 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number . Age (In yrs. last birthdey) Montha Deys 1□ M 20 F 58 135-34-0300 **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inaide City Limits Peges 1 and 2 should be filed within 72 hours eiter death with the Maryler nent of Health and Mentel Hygiene.

ant: If item 27 is marked other than "natural", or itema 23s or 28s-f show ury or other traumatic event, the Medical Express must be notified as 1 Ves 2 □ No Director Hunterdon Flemington 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 203 Main Street 08822 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 20 Married Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) College (1-4or 5+) Elementery/Secondary (0-12) Executive Administrative Asst. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Mary Ricci Carmine Dragotta 2 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Bruce H. Mason - Husband 203 Main Street Flemington, NJ saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method ot Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or Somerset Hills Crematory 8/9/00 4 ☐ Donation 5 ☐ Other (Specify) Basking Ridge, NJ 21. Signature of Funeral Service License 22. Name and Address of Facility Capitol Funeral Service, Inc. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, or heart tailure. List only one cause on each line. 22046 Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finat Traunatic Subarachnoid Hemorrhage disease or condition resulting In death) Examiner Blunt Head Examiner physician and s the buriel-trans Sequentially list conditions, if eny, laading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): 98 950 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 40 3 Probably 4 Unknown þ 24b. Wera eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 hes 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: director, 25. Was cese reterred to medical Be 26. Place ot Death (Check only one) examiner? Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28d. Describe how injury occurred Patient fell off boot 15 feet while in dry dock funeral 27. Mannar of Daath 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: After 1 Natural 5 Pending investigation 1540 PM efter death. 1 Yes 2 No July 26, 2000 2 Accident 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) for Manual City or Town, State) Herring To 6 Could not be determined 3 Sulcide in by 4 Homicida 24 hours 29a. Cartifier Medical (Check only one) 22-Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted. To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) H0055927 2000

3001 Hospital Drive, Cheverly, Mary Hand

30. Name end address of person who pleted ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

Eneral

DHMH 16 Rev 6/95

Registrar

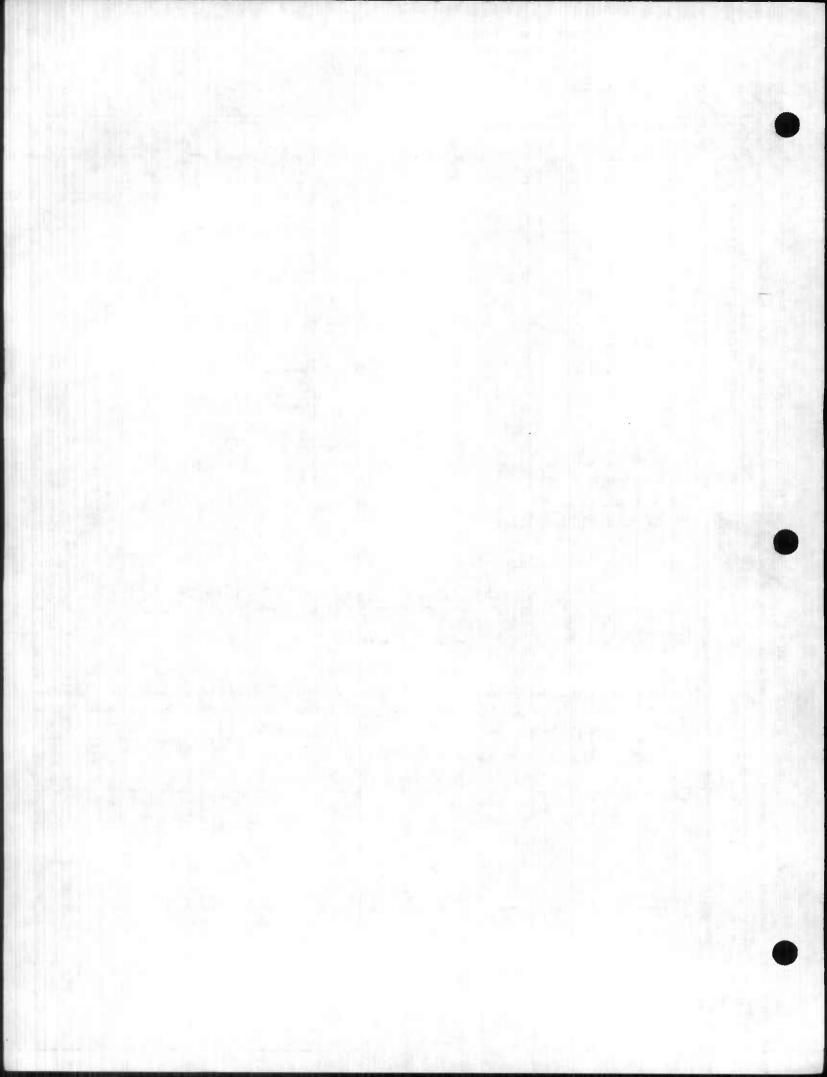
SALVAdon 31. Data tilad (Month, Day, Year)

AUG 0 7

Description provide

State of Maryland / Department of Health and Mental Hygiene 00 26797

				Cei	rtificate of	Death		Reg. No.		-0131
		1. Decedent's Name (First, Middle, La	est)				2. Dete of De Month	eath Dey	Year	3. Time of Death
	Physician	Thomas Patrick Jo	senh McCauley				August	0 000		9:15 pm
	/Medical Examiner	4a Facility Name (If not institution, give	re street and number)			4b. City, Town, or				
	LAditille	Clica Crook Nursi	na f Dahah			Takoma P	o mlr	Monto	000000	
1-	Funeral	Sligo Creek Nursi 5. Social Security Number 6.5	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	Montg	9. Birtho	place (Stete or Foreign
п	Funeral Director		1X M 2□ F 82	Yrs.	Months Days	Hours Min	Feb 2	7, 1918	Ohio	
()		Usual Residence of Decedent						,		
	dand dand	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	10d. Inside City Limits
	Many Lesh	Maryland Prince G	leorge's Ade	1phi						1 ☐ Yes 🏖 No
	or 28a-f s or 28a-f s be noutled	10e. Street and Number	corge b mae	-LPIII	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	sth with the Marylan 23a or 28a-f show stibe noutling at ral Director							State of the		
	r hama 234	1733 Metzerott Ro	12. Was Decedent Ever in U	S 12	20783	tispanic Origin? I	Specify Ves or N	USA 14 Rec	ce - Americ	can Indian,
	heme Iner me	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of H If Yes, specify Cub	an, Mexicen, Pue	no Rican, etc.)	Bla	ck, White,	
20	br, or	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yes 2♣ No	Specify:		Specif	y: Whi	ite
21215-0020			1	16a Daca	dent's Usual Occup	nation		16b. Kind ot B		
15	C 1 2 100	(Specify only highest gri	ade completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking	100.71110 010		20011)
12	filed within Hygiena. ott. me Mer	Etementary/Secondary (0-12)	College (1-4or 5+)		olic Brot			Religi	0116)rder
2	i Hygin other other of the Co	17. Father's Name (First, Middle, Last)	Cath	JIIC BIOL		me (First, Middle	, Meiden Sumer	-	ruei
an									0.5	
2	should ind Meni	John J. McCauley	There Shrintl	10h Maili	ng Address (Street	Winifre		has City as Tour	State 7il	n Code)
Maryland	C) a = []	19a. Informant's Neme/Relationship (, 6666)
	1 and 1 eaith m 27 ther tr	Howard F. Piller			Metzerot osition (Neme of	t Road,	Adelphi	MD 20 20c. Location	783	own State
0	A = E A	1 Disposition 3 D		emetery, cre	metory or other ple	ce)	Date	200. Location	· Oity Oi 10	JWII, Otata
altimore,	Pag ment ant: H	4 Donation 5 Other (Special	(v) Hol	y Tri	nity Ceme	tery	8/8/00	Mitchel	1, AI	4
a	Department Department Important: any injury once.	21. Signature of Funeral Service Lice	nsee		2. Name and Addre Francis J		c F. non	1 Uoma	Tmo	
00	89758	J. Klin Slile								ng, MD 20901
		23a. Part1. Enter the diseese, or com	plicetions thet caused the deat						DPZZ	Approximate Interval Between
	Physician	shock, or heart failure. List only	one ceuse on each line.						1	Onset end Deeth
d	/Medical	Immediate Cause (Final	. RECUR	OCN.	TACO	DAT	IN P	16.1ma	NIA	
	Examiner	disease or condition resulting in death)	a. ICECUIC	or as a conse	1 13>4	IICITI		201110	-	
	i i	Street Contract	The state of the s			00	0106	NITC	1	
	sæcuted n and ial-transit Examiner		b. CEREBRO Due to (c		COLATI		- NEM	01661	A !	
,	ertificate be swacuted ding physician and see as the burial-transit	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying	D09 10 (C	N es a conse	drience oil. NO!	HLEF	1 7-12-011	THE CT !		
292	sicia bur	Cause (Disease or injury that initiated events	C							
68760,	entificate be ling physicia as the bu	resulting in death) Last	Due to to	r es e consec	quence or):					
×	leath certifical ettending plate use as tale		d							
Bo	et the death of by the ettendeteched for us									
o.	thet the death ed by the ette detached for	Part It. Other significant conditions of	contributing to death but not res	ulting in the u				_/		to the cause of death?
0	Phot the	0 2E 4212, 15	OPPLIANCE	7 10		NFECTI		Yee 21/No	3∐ Pro	obably 4 Unknown
13,	2 88 2	(3) DEHYDR	ATION, C	Deon	DHARYA	LIENTDR	PASE -		7 24h W	Vere autopsy findings
0	been si should	1 3 METABO	OLIC BN	CBPH	HALO PI	ATHY.		s an autopsy formed?	av	vailable prior to ompletion of cause
ec	> 33 00 00	0 111/000=	-Q11(10) B	DERI	2,1060	ISAA DE		/	ot	t deeth?
<u> </u>	The lew requir	P Y LLEOF	1248100,(1)) (2014	170191	10	Yes 20 No	1	☐ Yes 2☐ No
Vital Records,	detent The lev certificate has rector, page 2 Be Comp	25. Was cese referred to medical				26. Place of De	eath (Check only	one)		
>		axaminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing	Home 5 Res	sidence 6 DOt	her (Speci	(fy)
0	er this neral di	27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time o	of 28c. Inju	ry at	28d. Describe	how injury occu	rred	
Division of	ath. r: Ath	1 Netural 5 Pending 2 Accident investigation		(0.)		Yes 2□No				
Vis	Ansecto ecto by the by the	3 Suicide 6 Could not b			reet, factory, office		28f. Location	(Street and Num	ber or Rur	ral Route Number,
Ö	tel or Attending P rs after death. In Director After tel in by the funer Certification:	TO HOMEON	building, etc. (Specif	<i>y</i> /			Only or the	Juni, 0.010,		
	houn houn y fille		nysician: To the best of my kno							
	in 24 hours in 24 hours he Funer pletaly fill edical	(Check only 2 Medical Examone)	miner: On the basis of examina and manner steted.	ition and/or in	ivestigation, in my	opinion, death occ	curred at the time	, date and piece	, and due t	to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the tuneral Medical Certification:	29b. Signature and title of certifier	AA. Mans	mm	29c. Licen	se number	2	29d. Dete sign	ed (Month,	, Day, Year)
		Marinim	COT IN THE VIVO		172	459	5	8,0	5.0	0
	6	30. Name and address of person who	completed cause of death floor	n 23e) (Time	Print) O O D	2	221	TOLET	In T	FOUNC
		MOHAMMED	Completed cause of death files	HAN	MIN	.) 1	シュー	T()(1)	16	MD. 20782
	01-1	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature #	1	<i>J</i>		12011	الساء	1010101
	State Registrar	AUG 0 7 20	nn Line	9.	pouls					
	negistial	MOG 0 1 20	00	/	//					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Aug. Dey3 MC GOLDRICK 2000 Jerome 3:43pm 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Montgomery Silver Spring Holy Cross Hospital If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month Day, Year) Jan 15, 1930 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) DA Days Months Hours 1₽M 2□ F 70 Yrs. PA 157-20-7096 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring 1 Yas 2 No Montgomery 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 20902 IISA 2424 Dennis Ave. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11 Marital Statue I ⊠ Yes 2 □ No 1947— If Yes, Give Yaar or Detes: 1952 1 ☐ Navar Married 2 ☑ Married White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1952 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Automobile Salesman 18. Mother's Neme (First, Middle, Maiden Sumema) 17. Fether's Neme (First, Middle, Last) Pauline Hennigan Jerome McGoldrick 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2424 Dennis Ave, Silver Spring, MD 20902 Jean G. McGoldrick/wife 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 7 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 2000 Alexandria, VA Metropolitan Crematory 22. Nama and Address of Fecility 21. Signeture of Funeral Servica Licansee Francis J. Collins Funeral Home 500 University Blvd. W. Silver Spring MD 20901 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth hours Immedieta Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or es e consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atheroscleratic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

288-4 must be notifi

23a or

or Herrie

Pages 1 and 2 should be filed within 72 hours after mind of Health and Mentali Hydjens.

Lift Ren 37 is marked other than "natural", or the ary or other traumetic event, the Medical Exemice.

Baltimore, Maryland 21215-0020

the Medical Examiner

Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran signed by t by Be Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified the funeral director, Medical Certification: To filled in by

Division of Vital Records, P.O. Box 68760,

DiaBeter

examiner? 1 ☐ Yes 2 ☑ No	Hospitel:	ER/Outpatient	3□ DOA Other	4 ☐ Nursing Home	5 ☐ Residence	6 □Other (Spec
. Menner of Death	28a. Dete of Injury (Month, Dey Year	28b. Time of Injury	28c. Injury (Work?	at 280	I. Describe how inj	ury occurred

27 1 Yes 2 No М 2 Accident Investigation 6 Could not be 3 ☐ Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one)

29d. Dete signed (Month, Day, Year) 29b. Signatura and 29c. Licensa number AUGUST 3, 2000

ss of person who completed cause of deeth (Item 23a) (Type, Print)
RAYMOND BAS 5 2941 FE 30. Name and add 3941 FERRAMA RAYMOND

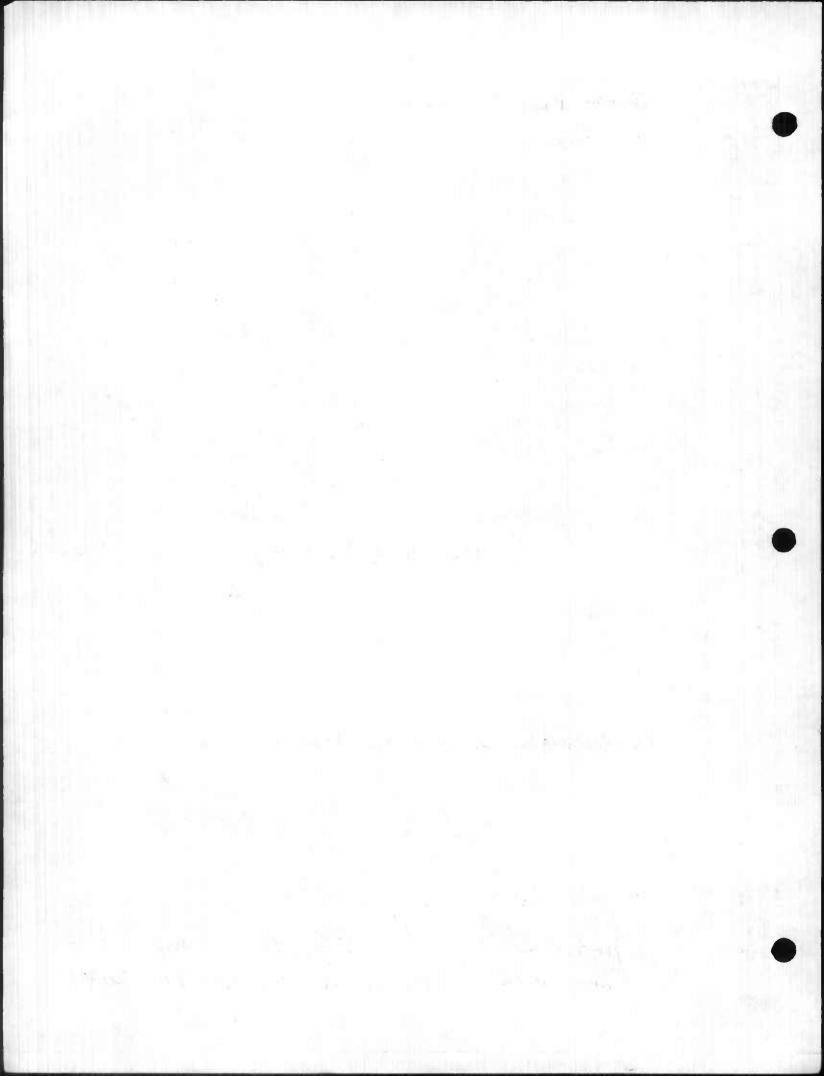
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State Registrar

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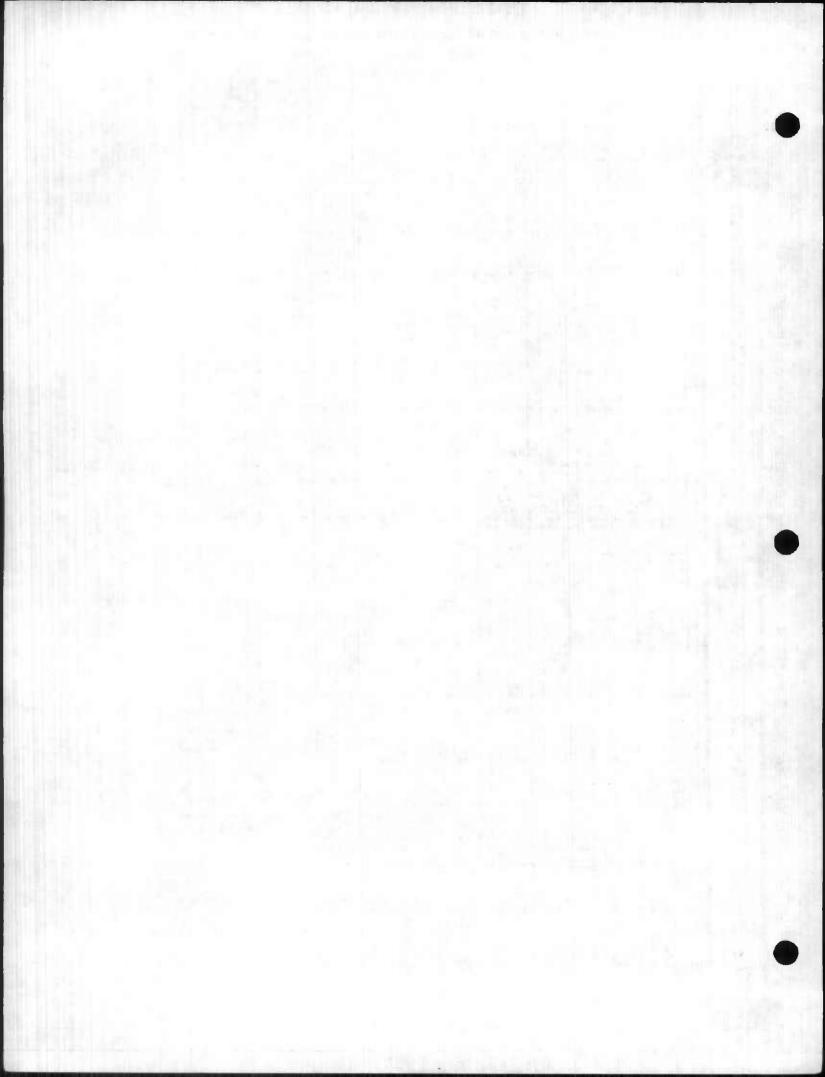
31. Dete filed (Month, Day, Year) AUG 0 7

32 Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 26799

					Certifica	ate of	Death		R	eg. No.		
		1. Decedent's Neme (First, Middle, L	ast)						2. Date of Dea			3. Time of Deeth
	Physician	Gratian J. Mey	er					F	August	5, Day 2000	Year	8:05 am
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	Examiner	as seminary morning					011					
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	P Funeral Director	577-12-6446	18 M 2□F		Yrs. Month			Min.	8. Dete of Birth (Month, Day			plece (State or Foreign ntry)
Ш	Director	Usual Residence of Decedent		13		1		11	May 19,	1921	wasn	ington, DC
	Bu Bu	10a. Stete 10b. County		10c. City, Town	n or Location							10d. Inside City Limits
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	her death with the Maryla r thems 22e or 28e-f show sher must be notified at Furneral Director	11. Marital Status	12. Was Decedent Armed Forces?		If Yes, s	pecify Cub	en, Mexican	, Puerto R	rify Yes or No- lican, etc.)		k, White,	
20	Frank Dy F		1 X Yes 2 If Yes, Give	No	1 ☐ Yes	2 🗓 No	Specify:			Specify		
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5	in 72 ho natural sedical	15. Decedent's (Specify only highest g	Education rade completed)	16a.	Give kind of	work done	during most	t of working	0	16b. Kind of Bu	ISINOSS/IN	idustry
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Maryland 21215-0020	S and a second	19e. Informant's Neme/Relationship	(Type, Print)	19b	. Mailing Addre	ess (Street	t and Numbe	er or Rurai	Route Number	r, City or Town,	State, Zip	o Code)
	ard 27	Kathryn S. Meyer	/ Wife				Terra	ce, S		Spring,	-	20906
ore	1 年 1 日	20e. Method of Disposition		20b. Place of cemeter	Disposition (A	Vame of or other pla	ice)	- 1	Date	20c. Location -	City or To	own, State
Ĕ	Pag nert ny o	1 Burlel 2 N Cremetion 3 4 Donation 5 Other (Spec			olitan			8/	6/2000	Alexand	dria	. VA
altimore,	in a support	21. Signature of Funeral Service Lice	ensee /	1100101								neral Home
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	Physician /Medical	Immediate Cause (Final	0 1	1		1 .						
	Examiner	disease or condition resulting in death)	a. Cerebr	ovascula	ar Acci	dent						5 days
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	death certificate be assecuted at a stending physician and ad for use as the bunal-transit sician/Medical Examiner	Sequentially list conditions,		Due to (or as a	consequence	ot):						
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00	_ H &	Flostate Cancel							perfor	megr	CC	ompletion of cause
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ā	certificate rector, pag		Disease						10 Y		1	Yes 2 ANo
3	Physician: this certificated director,		Hospital:			Ot	her		(Check only or			
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sic	Attending or death. Actor: After fune by the fune iffication	2 Accident Investigati 3 Suicide 6 Could not			М	1	Yes 2 1					
Division	after death Director: , d in by the	4 Homicide determine	200. Flace of In	jury - At home, fa c. (Specify)	rm, street, faci	lory, office		21	Bt. Location (S City or Tow	treet and Numb n, Stete)	er or Rur	rel Route Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:											
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	in 24 hours he Funer pletch fill	one)	miner: On the basis o end menner st		a or mivestigeti	wii, iii iiiy i	opinon, deel	occome	cat the time, C	ota anu piece, (J. 100 UUB I	io ine cadse(s)
	within 2 to the comple	29b. Signature and title of certifier			1	29c. Licen	se number	114.		9d. Date signed	_	
	4+1) (Weller			1	D 47	7654		1	August 6	0,20	000
	73	30. Name and address of person who	completed cause of o	seeth (Item 23a) (Type, Print)					0		
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	State	31. Date tiled (Month, Day, Year)		ar's Signature	. Moau	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100	J, III	actsvI	LIC CHI		
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State of Maryland / Department of Health and Mental Hygiene

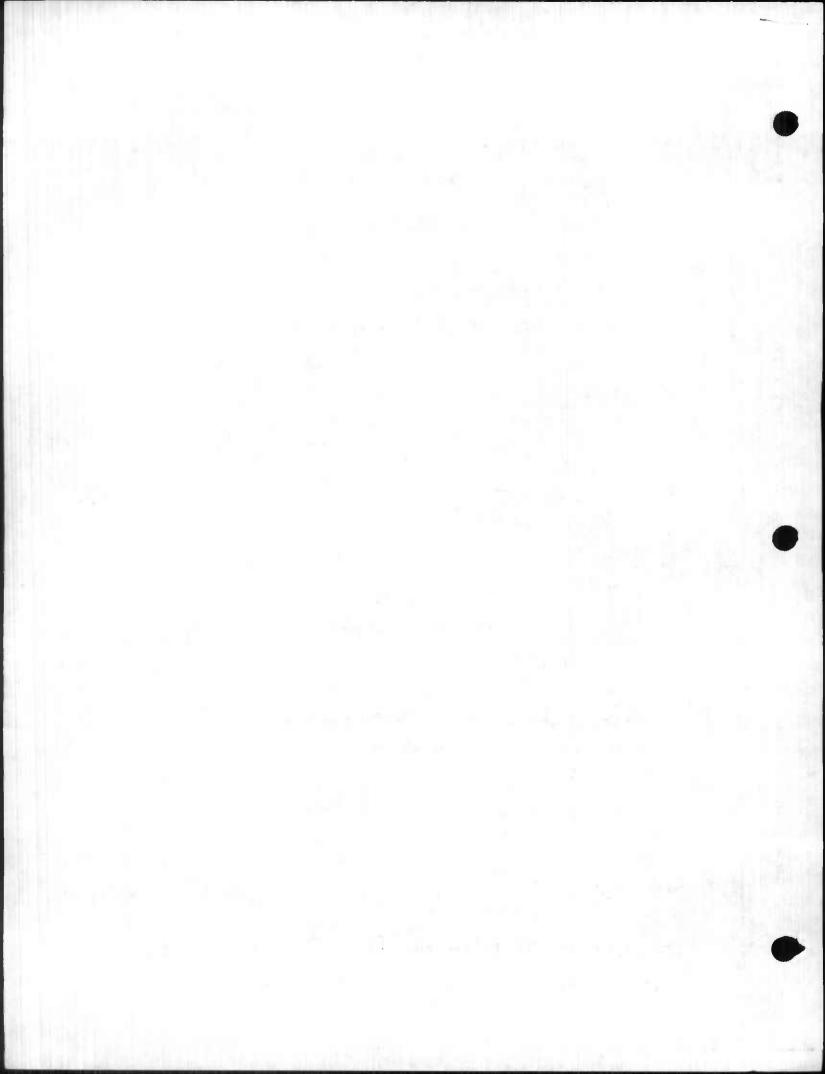
Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 0750 4b. City, Town, or Location of Death Donna Marie Miller 2000 /Medical 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Fallston General Hospital Fallston Harford If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yeer 8. Dete of Birth (Month, Day, Yea January 10, 7. Age (in yrs. last birthday) Birthplece (State or Foreign Country) O. 1948 **Funeral** 1□ M 25 F Months Deys 216-52-4785 52 Yrs. Maryland Director Usuef Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show 1 ☐ Yes 2 No MD Harford Director Edgewood the Medical Examiner must be notthe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barns 23a or 901 D Swallowcrest Ct 21040 United States Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 6 Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within al Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing Factory 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) h and Mental ? Is marked of Lois Dena Nicholson Cletus Eugene Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) Pages 1 and 2 s ment of Health an ant: If Nem 27 is Lois Dena Stoner / mother 901 D Swallowcrest Ct Edgewood, MD 21040 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete ð 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory, Inc 8/5/00 Beltsville, MD 21. Signeture of Funerel Service Licensee CAFA Stephen D. Lohrmann, P.A.

Pactures Dr., Towson, MD 21286

Approximately approxim 22. Neme and Address of Fecility any 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Laura C Hardesty Approximate fnterval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner neumonia Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) The law requires that the death certificate be exec New tropenia Miller Bonna Marie Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part ff, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown h 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? page 2 should Be Completed this certificate has ASCVI 1 Yes 20 No 1 Yes 2 No of Vital or Attending Physician: after death.

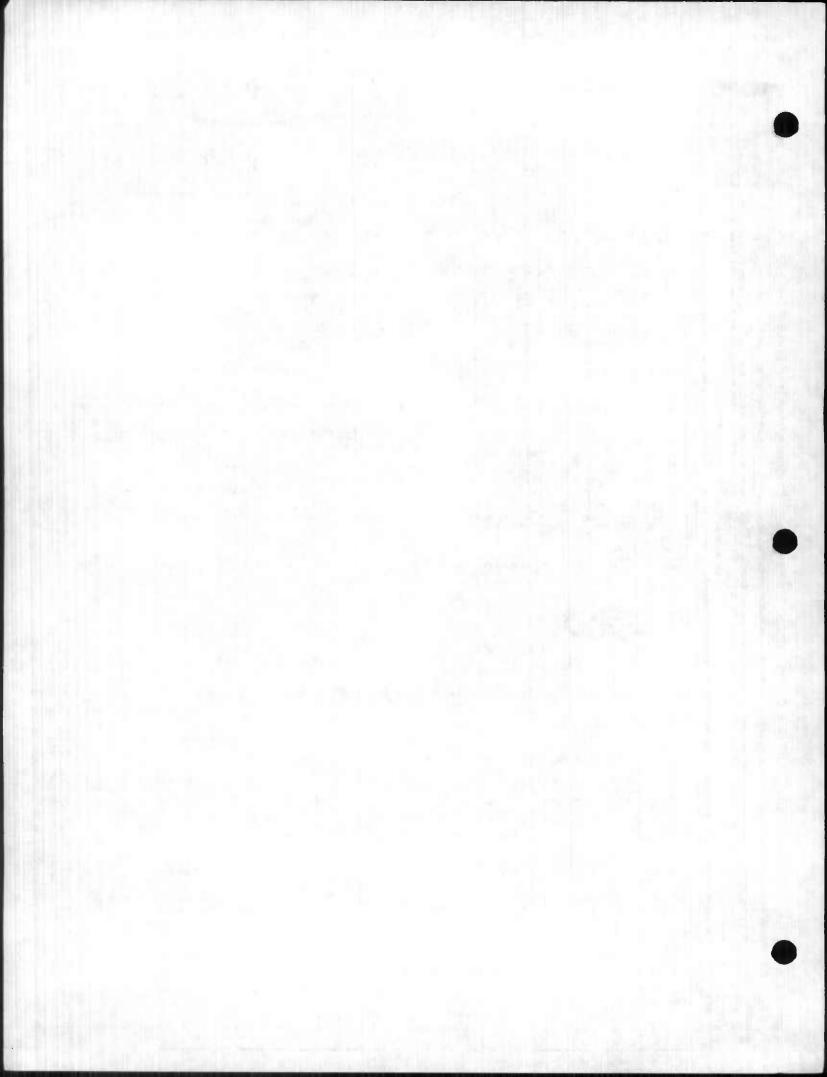
Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 20 No Medical Certification: To 27. Manner of Death 1 Deneturet 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, lerm, street, fectory, office building, etc. (Specify) illed in by 4 | Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the causa(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier Adam FAILL, MD 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holam FAILL. 206 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State AUG 09 Sepera Registrar



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	20e. Method of Dis	sposition		20b. Plec	e of Dispositio	on (Neme of	ca)	Dete	20c. Location -		m, State
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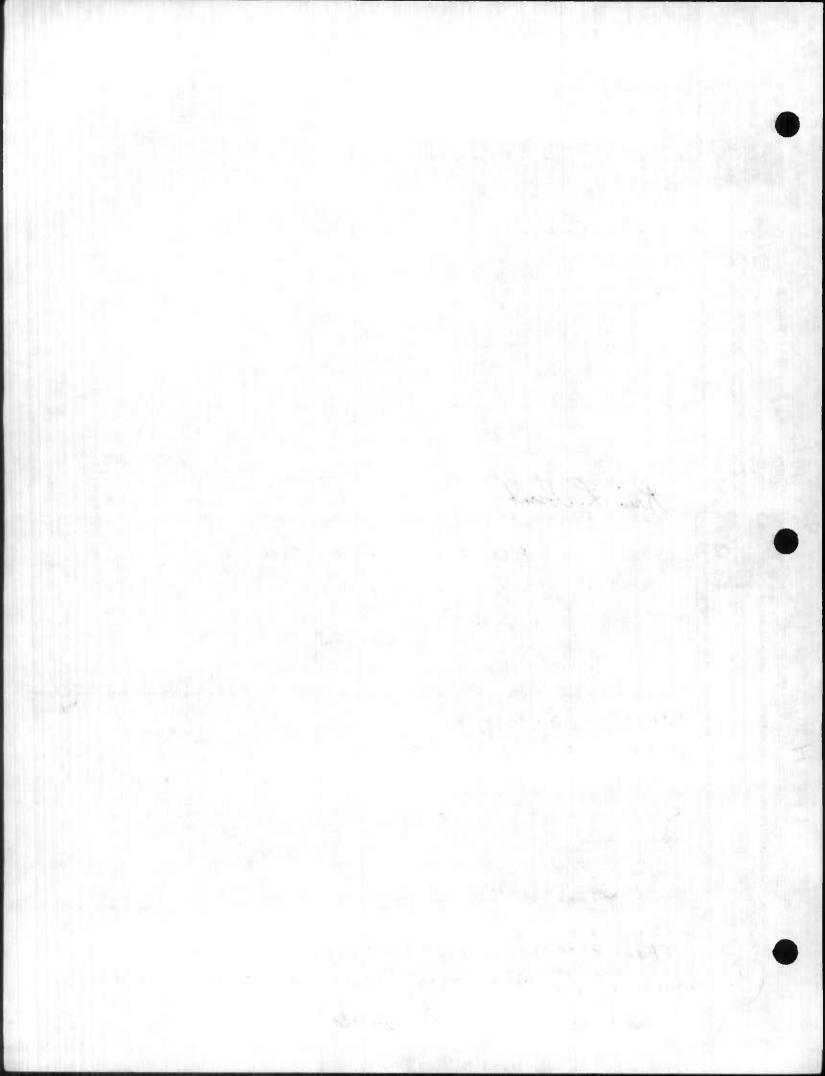
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

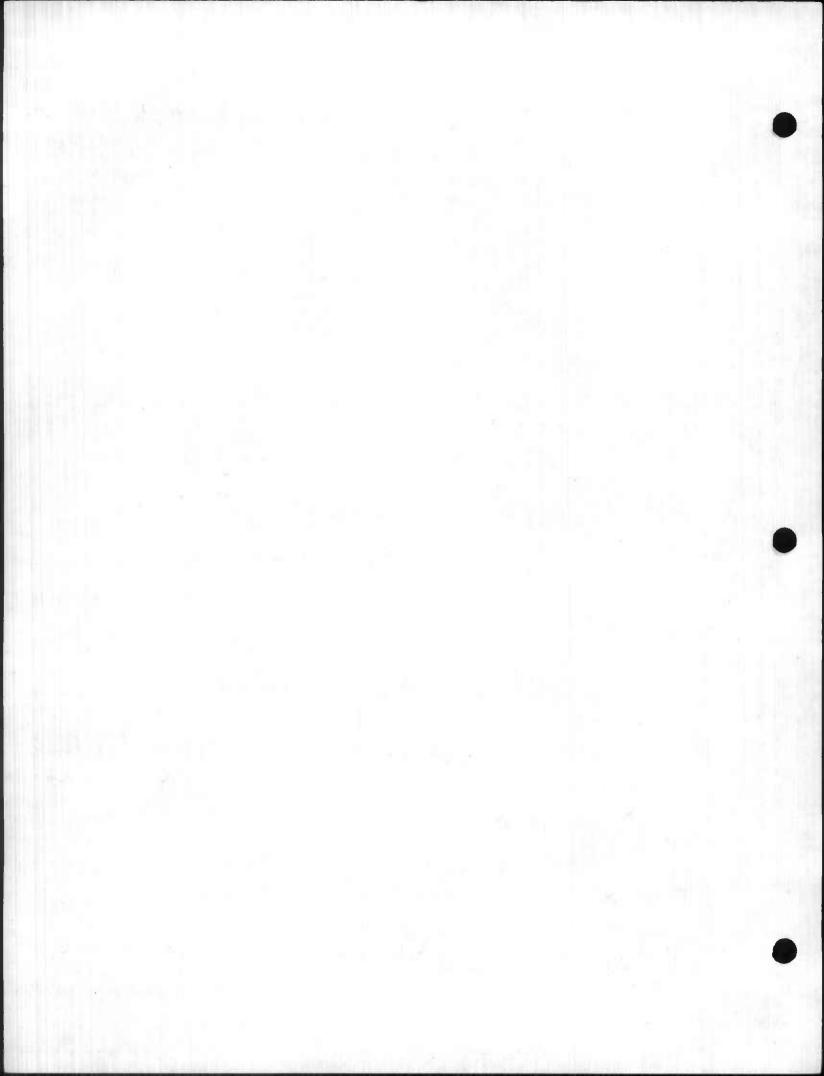
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	1. Decedent's Neme (First, M	iddle, Last)					2. Dete of De	eth Dey	3. Time of Death
Physician /Medical	Hetty	Orr					Aug 7,	2000	2:34 P.M
Examiner	4a Facility Neme (If not institu	ution, give street end number	er)			lb. City, Town, or Li	ocation of Deet	4c. County	of Deeth
	Southern Mar	yland Hospit	al			Clinton		P.G	
Funeral Director	5. Social Security Number 122 52 1665	1□M 20 F	Age (In yrs. last L 86		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 7	th ly, Year) , 1914	9. Birthplaca (State or Foreign Country) Trinidad
S	Usuel Residence of Decedent 10a. Stete 10b. Cou		10c. City, To	own or Location	on				10d. Inside City Limits
dary f sho or	MD I	P.G.	Clir	nton					1 □ Yas 2 No
or 28s-1 s be notified Director	10e. Street and Number			11	10f. Zip Code		[10g. Citizen of V	Vhat Country?
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her douth r home 23 siner must Furneral	9106 Pinevie	12. Was Decede	nt Ever in U,S.	13. Was		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		e - American Indian,
in after death with the Marya if, or here 23a or 28e4 sho traminer must be notified at by Funeral Director	1 Never Merried 2 N	if Yes. Give?	No		Yes No	Specify:	Rican, etc.)	Specify	ck, White, etc. Black
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d within gione. ir then	10	27 Gollego (1 4)		Housew	ife			Own Ho	me
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Ment Ment Went the street of t	UNKNOWN	Ferguson				Lucy	Lemon		
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Pages 1 want of H nit: If lise rry or off	20a, Method of Disposition 1 X Buriel 2 Cremati 4 Donetion 5 Othe	on 3 Removal from Ste	te ceme	of Disposition of Dis	ory or other plea	Aug 12,	2000		city or Town, State , Maryland
Desmit. Departr Imports any inju	21. Signature of Funerel Serv	Licensed		22. Na	ame and Addre	ss of Fecility Lee	Funera	l Home,	Inc 6633 Old
	23e. Perf1. Enter the diseese	or complications that cause	sed the death. De	ALEX o not enter th	andira	Ferry Ro	or respiretory a	rrest.	Approximate Interval Between
Physician /Medical Examiner Washington and the control of the con	tmmediate Cause (Finel disease or condition resulting in death)	a/	Due to (or es	e consequer	100 of):	y FAIL	YRE		
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v requ	CHRONIC	PICHT UP	PER L	UBE	IMFIL	TRATE	24a. Wes	en eutopsy ormed?	24b. Were autopsy tindings sveilable prior to completion of cause of death?
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ysician: s certifica director,	25. Wes case referred to med examiner?					26. Place of Deel	th (Check only	one)	
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5 2 5 0	Z LI ACCIDOTIL	estigetion	Day Year)			yat k? Yes 2 □ No		how injury occur	
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To the within to the company of the	29b. Signature end title of cer			1111111	29c. Licens	e number		29d. Date signe	d (Month, Dey, Year)
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(3)	30. Neme end address of pers			a) (Type, Prir	14				
State Registrar	31. Dete filed (Month, Dey, You AUG 10	ear) 32. Regi	strer's Signeture		portal				- T-A (A6)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Year **Physician** limofei ORLOVSKY 1000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthpiace (State or Foreign Country) **Funeral** Days Hours 15M 20F Months 155-26-2820 81 Jan. 1, 1919 Director Russia Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ra 23a or 28a-f show 1 ☐ Yes 2 ₺ No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8206 Cedar Street 20910 USA Herman Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Medital Status the Medical Examiner Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 21215-0020 6 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Clerk Publishing Pages 1 and 2 should be filed witness of Health and Mental Hygier traint: If New 27 is marked other trainty or other traumatic event, the Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Josif Orlovsky Daria Orlovsky 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alexandra Voron / Executor 1511 Jasper Street, Silver Spring, Maryland 20902 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Rock Creek Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 08/08/00 Washington, DC Departm Importar any Inju 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue 21. Signature of Funeral Service Licensee Silver Spring, Maryland niter the disease, or definplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical mediate Cause (Final Myeloid fiboones - metaplace disease or condition resulting in death) Due to (or as a consequer Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 □ Yes 2 No 3 Probably 4 Unknown tract refection Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy · Dehydration completion of cause of death? 25. Was case related to madibal examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 Yes No. Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 100 28d. Describe how injury occurred 27. Manner of Deat 28c. trijury at Work? Affect Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attent within 24 hours after dest To the Funeral Director: 3 [7] Suicide 6 Could not be 25e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hamicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08-05-2000 008188 6 Crawen 30. Name and address of person who completed cause of deeth (fluor 23a) (Type, Print) G GRAZIANI PERSHING DRIVE STUENSPANSAMD 20910 HUGO Mn 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State senera AUG 0 7 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Deeth 3. Tima of Death **Physician** Jose Alfredo Perez August 9, 2000 10:19 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1X M 2□ F Yrs. Puerto Rico 352-74-6444 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Maryland Prince George's Beltsville Norna 23a or 28a-t plens. r than "natural", or Nems 23a or 28a-the Medical Examiner must be notifi 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 11208 Evans Trail, Apt. T3 20705 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian Black, White, etc. a filed within 72 hours after if Hygiene. other than "natural", or its 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 Specify: Puerto Rican YO Yes 2 No Specify. by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Educetion (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 11 n/a 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Could be Mental Perez Amalia Julio Mendez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: if then 27 is a say injury or other to says. Elizabeth Perez - Wife 11208 Evans Trail, T3, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 X Burlal 2 ☐ Cramation 3 X Ramoval from Stata 8/14/2000 Sebastian, Puerto Rico 4 ☐ Donation 5 ☐ Othar (Specify) Pepino Memorial Park 21. Signature of Funeral Service Liberasee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on aach lina. Approximata Interval Between Onset and Death **Physician** RESPIRATORY /Medical Immediate Cause (Final disease or condition rasulting In death) years **Examiner** ERMANSKY - PUDLACK SYNDROME Physician/Medical Examiner igned by the attending physician and be detached for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury Box 68760. that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy tindings available prior to completion of causa of daath? To the Hospital or Attending Physician: The law require within 24 hours after death.
To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should be Completed 24a. Was an autopsy performed? 1 ☐ Yes No Be 25. Was cese raferred to medicel 26. Placa of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death

1 Natural

2 Accident 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide Medical 29a. Certifier Certifying Phyeician: To the bast of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as statad.

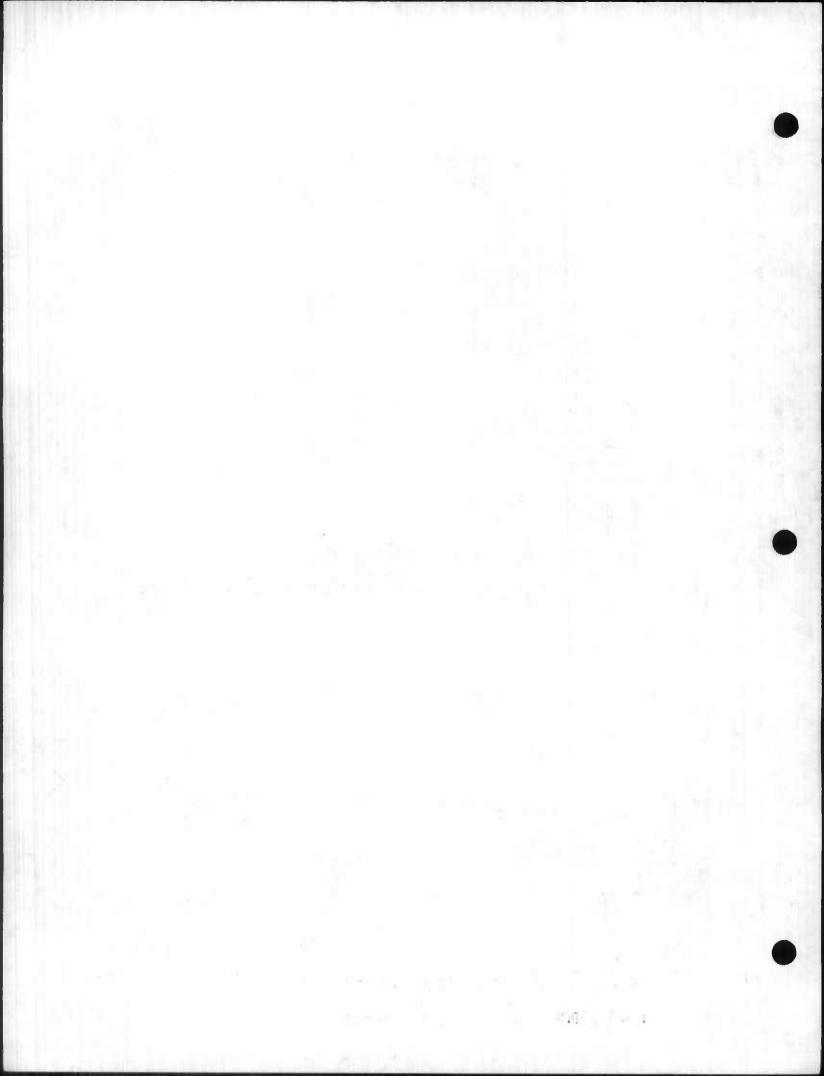
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated. 29c. Licansa number D 42403 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifier of death (Item 23a) (Type, Print) NO STREET, NW WAShington be

Registrar

State

31. Data tiled (Month, Day, Year)

AUG 1 1 2000



State of Maryland / Department of Health and Mental Hygiene 00 26805

			Cei	rtificate	of L	eath)			Reg. No.					
Sharinia.	1. Decedent's Name (First, Middle, Las.)						2. Date of De Month	ath Day	Yeer	3. Tim	a of Death		
Physician /Medical	Marie N. Prout							August		2000	8:3	0 P.M.		
Examiner	4a Fecility Name (If not institution, give	4t	b. City, To	wn, or Lo	ocation of Deat	ath 4c. County of Death								
S	Hebrew Home of G	reater Washing	gton			Rock	vill	е	Mon	tgome	ry			
Funeral	Social Security Number 6. Se	7		If Under 1 Months	Year Deys	If Under Hours	24 Hrs. Min.	8. Dele of Bir (Month, Da	th y, Year)	9. Birthp	lece (Sta	nte or Foreign		
Director	213 22 1937	² M ² √x ^F 80	M 2LTF 80 Yrs.					Nov. 5						
2 -	Usual Residence of Decedent	1 400 00	. Town and a	antina							0.4.414	- Ola I I I I I I		
Maryla a-f show lifed at	10a. Stete 10b. County 10c. City, Town or Location Maryland Prince George's Bowie										10d. tnside City Limits			
ser death with the Marylar litems 23s or 25s4 show lost must be notified at Tuneral Director	I IZIVV MAVCHECK Da	ne 10f. Zip Code 207				5		-7	10g. Citizen of What Country? United States					
her death r Items 23 sher must Funeral	11. Marital Sletus	12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto)						ecity Yes or No	- 14. Re	Rece - American Indian,				
	Year Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	1 Yes 2 No			Specify:		Hican, etc.)	Specify: Black					
Maryland 21215-0020 d 2 should be filled within 72 hours at the and Membal Pyglane. T is marked other than "natural", or trearmeds event, the Medical Exam To Be Completed by 8	15. Decedent's Ed (Specify only highest grad	ation 16a. Decedent's U completed) (Give kind of life. DO NOT			Occupa done di retiredi	tion uring mos	t of work	ing	16b. Kind of Business/Industry					
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O of the Co		U	Home	Homemaker		18. Mother's Neme (First, Middle			lle, Maiden Surname)					
o Be							knowi							
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md 2 s	Verna Teasdale	P.O.A.	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12100 Maycheck Lane Bowie Maryland 20715							0000)				
ETNL	20e. Method of Disposition										wn. Stet	A		
Pages ment of ant: If h ury or o	Rurlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		cometery, cres					9 ^{Date} 200	O Chelte					
Dallimore, permit. Pages 1 a Department of Hes important: If ham any injury or othe ansis.	21. Signeture of Funerel Service Licens	100 Day	R		E.]	Evans	Fui		ome, In					
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	shock, or heart tailure. List only of	ne ceuse on each line.	n. Do not on	tor the mode.	or dying	y, odori do	ou. diao	or roophotory a		1	Interval	Between and Death		
Physician / /Medical	Immediate Cause /Final													
Examiner	Immediate Cause (Fine) disease or condition resulting to death) 8 Heart Failure 2 Days											ys		
	resulting in deeth) Due to (or as a consequence of):													
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eath certificate be executed attending physician and for use as the bunal-transit clan/Medical Examiner		Due to (or es e consequenca of): Morbid Obesity												
ifficate be ex g physician a es the bunal.	thet initiated events resulting in death) Last	Due lo (c	or es a consec	quence of):										
ding plant p														
ath cert for use		d. Lung Mass												
. 0 00 -	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Dld	23b. Did tobacco use contribute to the cause of death?					
\$ 60 F						1 Yes 2 No 3 Probably			bebly	Unknown				
2 2 2 2								24n Mac	24a. Was en autopsy 24b. Were autopsy tindings					
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D 2s D									of death?					
The la								10	Yes 2 No	10	Yes	2 No		
ysician: The securificate director, pag						26. Place	e of Deet	th (Check only	one)					
- K 50 5		Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Othe	1: 4 NI	ursing Ho	ome 5 Res	idence 6 🗆 O	her (Specif	y)			
g Physical dispersal di		28a. Date of Injury 28b. Time of 28c. Injury at Work?						28d. Describe	how injury occu	rred				
I or Attending after death. Director: After d in by the fune entification	1 Natural 5 Pending 2 Accident investigation	tion M 1 Yes 2 No												
tal or Attending P is after death. al Director: After ted in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)												
S after	4	oditality, etc. (opeon	77						, ,					
To the Hospital or Attending Physician 2 to the Fureral Director: After th completely filled in by the funeral Medical Certification:		sician: To the best of my knowner: On the basis of examina	owledge, deet	h occurred et	the tim	e, date an	nd place, ath occur	end due to the	ceuse(s) and n date end place	anner es s	tated.	ıse(s)		
the the plant		and menner steted.									0			
To the com	29b. Signature and title of certifier	0.11.	117			number	(20	29d. Date sign					
	1 / m	Cull	N	0	10/	164	200	DC	8	-7	ac	000		
161	30. Neme and address of person who c	ompleted cause of deeth (Item	m 23e) (Type,	Print)	00:	511	10		\ -					
(b)	30. Name and address of person who c	mpleted cause of deeth (Iter	Capit	Print) D	166	t N	E.	Wash.	D.C.	200	07			



Please Type or Print In Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 26806

ysician					00	tirious	CUI	Death			Reg. No.			
ysician	1. Decedent's Nam	ne (First, Middle	, Last)				TEA			2. Date of D Month		Van	3. Time of Death	
12	Joseph Anthony Pancamo										3, 200	O	14:25	
ical iner	Joseph Anthony Pancamo 4a Facility Name (If not institution, give street and number)						4	4b. City, Town, or Location of						
r									nton			P.G.		
4			yland Hosp		and high day	Hilada	r 1 Yeer	If Under		P Date of D			place (Christian Francis	
	5. Sociel Security 1 088 16 65		6. Sex 7 1□XM 2□ F	Age (In yrs. II 82	Yrs.	Months		Hours	Min.	8. Dete of B (Month, D Oct 8	ay, Year)	9. Birth	place (State or Foreign ntry) YOTK	
L			7.		113.					UCT 8	, 191/	INEM	TOTK	
-	Usuei Residenca d	10b. County		100 01	Tour	notion							10d. inside City Limits	
			Toc. City	10c, City, Town or Location Upper Marlboro										
Director	MD	P.G.			Upp	er Pk	TILL	DIO				-	1 □ Yas 2 No	
	10e. Street and Nu	imber	C. STA		311 9	10f. Zi	Code	1.77			10g. Citize	en of What Cou	ntry?	
ruinerai D	9801 Luk	Court		20772						Uni	United States			
	11. Meritai Status	e court	12. Was Decede	nt Ever in U.S	5. 13.	Was Dece	dent of H	ispenic Or	igin? (Spi	ecify Yes or N	10- 14	14. Raca - American India		
Ì		ried 2 Marrie	Armed Force	□No 1943			cify Cuba	Cuban, Mexicen, Puerto Rican,				Black, White,	, etc.	
	Widowed		If Yes, Give Yeer or Dete	e 104		1 🗆 Yes	2 X /No	Specify			S	specify: Typ	nite	
				s: 194		dent's Lie	al Occur	etion			16h King	d of Business/Ir		
1	(Spe	15. Decedent' city only highes	s Education t grade completed)		16a. Dece (Give	kind of wo	ork done	ation du <i>ring</i> mos d)	st of work	ing	TOU. NING	. J. Duaniess/II	iousiny	
Soundings.	Elementary/Sec	ondery (0-12)	College (1-4d	or 5+)							ion Ct	ato Do	nartment	
1	1	2		4	ASSIST	ant	nie						partment	
0	17. Father's Name	(First, Middle, L	.ast)					18. Moth				n Sumame)		
	Anthony	Panca	omo						Ro	salie	uniane	erra		
	19a, Informent's N	lame/Relationsh	ip (Type, Print)		19b. Maili	ng Addres	s (Street	and Numb	er or Run	al Route Num	ber, City or	Town, State, Zi	p Code)	
	Tom Pan	camo (S	OM)		9801	Luke	Cou	rt, U	pper	Marlb	oro, M	Marylan	d 207/2	
1	20a. Method of Dis	position			ace of Dispo	sition (Na	me of			Date	20c. Loca	ation - City or T	own, State	
	14 Burial 2	Cremation	3 Removal from Sta		metery, cre				7	2000	Charl	otte H	all, MD	
		5 ☐ Other (Sp		ALL	Faith	ı cem	ecer	y Aug	Too	Linor			6633 Old	
	21. Signature of Fi	uneral Service L	icensee		2:	2. Name a	nd Addres	ss of Facil	ity Lee	-a cl	ar na	Marvil	and 20735	
		10:	R. H.	1120	A	Lexan	dria	Ferr	y Ro	aa, CI	inton,	, raryl	and 20735	
1	23a. Part1. Enter	the disease, or	complications that caus	sed the deeth	. Do not en	er the mo	de of dyln	g, such as	cardiac	or respiretory	arrest,	1	Approximete	
23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.										Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in deeth) a. HEPATIC FAILURE Due to (or es a consequence of):									2 WKS				
	diseese or condition resulting in deeth)	on	a	HE)	071		-	MIL	VR			1	LNLS	
				Due to (or	es a conse	quenca of)								
EAGIIII 16			- b. M	ETA	SIA	SE	S	70	TH	E LI	VER	i	MONTHS	
	Sequentially list co	onditions,		Due to (or	as a conse	quenca of)								
1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events to the condition of the conditions of t										YEARS			
	that initiated event resulting in death)	S	C	Due to (or	es a consec	uence of)		/	1				1	
Medical	i counting in coatin)	mad gri	De la companya della companya della companya de la companya della									1		
2			d											
Physician	Part II Other slow	ficant condition	e contribution to don't	hut not reco	ting to the	nderhine	COLLEG CH	en in Part	1	23h Di	d tobacco u	ss contribute	to the cause of death?	
20	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death?					
	1 Yss 2 No 3 I									11	Y88 2	TNO 3 Pro	DEDIY 4 UNKNOW!	
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				24a. Was en autopsy performed?								a a	Vere autopsy findings vailable prior to ompletion of cause	
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To annual man and an	examine?] No	1 Impa	-	ER/Outpetie		UA	er: 4 N		per 1 ☐ h (Check onl) me 5 ☐ Re	Yes 22/one)	No 1	f death? ☐ Yes 2☐ No	
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State of Maryland / Department of Health and Mental Hygiene

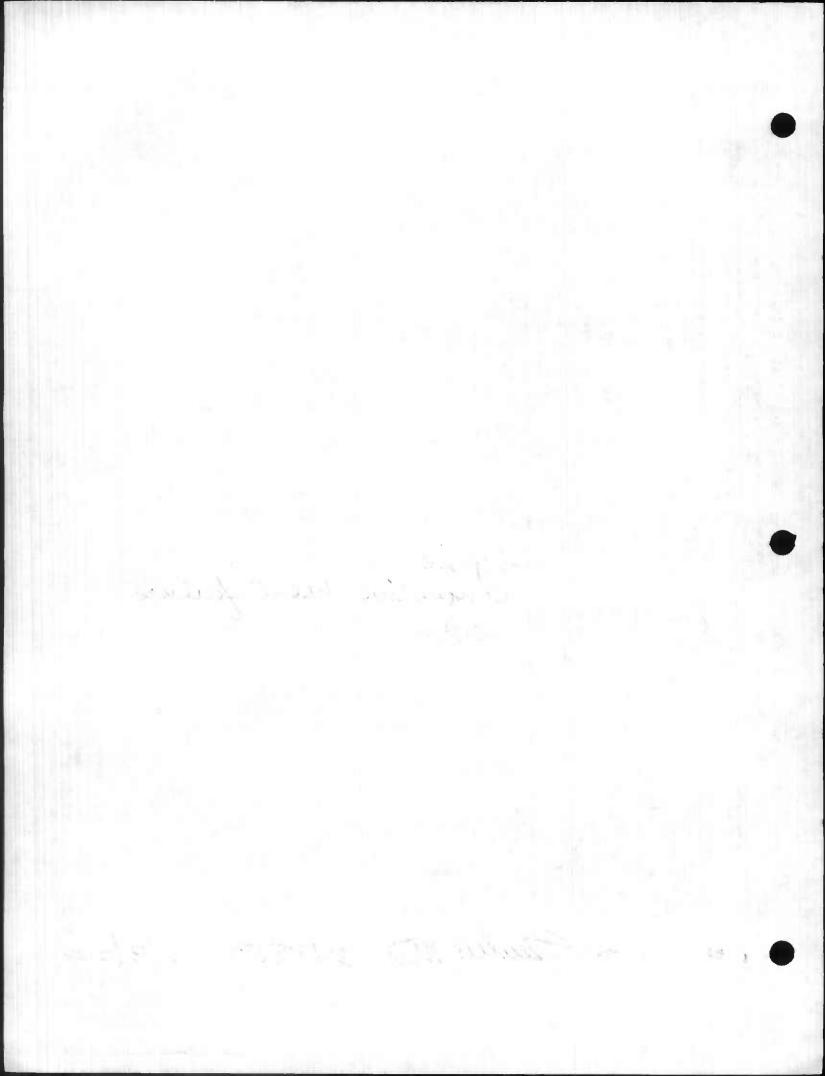
Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:08 pm August 4, 2000 D. Michael Perry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8. Dete Holy Cross Hospital Montgomery 6. Sex 1X M 2 ☐ F 8. Dete of Birth (Month, Dey, Year) Dec 25, 19 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 83 Yrs. 1916 Pennsylvania **Director** 577-30-5703 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1X Yes 2 □ No Directo Maryland Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 he Medical Examiner must be natural, or liams 23s. 20853 13305 Keating Street USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Stetus Black, Whita, etc. 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P It Yes, Give Year or Detes: 3Ã Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiana. I other then Elementery/Secondary (0-12) College (1-4or 5+) Medical Supplies Sales 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 should be financial by its marked of Michael Perry Lo Ermelinda Nicastro permit. Pages 1 and 2 sth. Department of Health and Important: if Nem 27 is me. any Injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn D. Perry / Daughter 13305 Keating Street, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☑Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/10/00 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. KeinS 500 University Blvd., W. Silver Spring, MD 20901 23a. Pat. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting In death) /Medical Examiner Examine attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resuiting in death) Last Box 68760 certificate be Physician/Medical (or as e consequence of): 98 P.O. detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy Completed page 2 After this certificate has 1 Yes 2 No 1 ☐ Yes 21 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Naturat 5 Panding Investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident after deeth the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) #304, Silver Spring, MD Ira Tauber, MD 10301 Georgia Ave. 20901 31. Date filed (Month, Day, Year) 32. Registrer's Signeture oouts State Coper

DHMH 16 Rev 6/95

Registrar

AUG 0 7 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1, Decedent's Nama (First, Middla, Last) 2. Date of Death Month Dev Vaar 2'000 0637 IUIAN 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nama (If not institution, give street and number) Georges Prince beorges Hospital Center MD Cheverly If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth Months Days Hours Min. April 21 9. Birthplace (State or Foreign 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6 Sax Pennsylvania Year) Months 1□M 2√F 579-34-3647 83 Yrs. Usual Rasidenca of Dacedent 10d. Inside City Limits 10h County 10c. City. Town or Location 1☐ Yas 2☐ No P.G. Bowie 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 15715 Pointer Ridge Drive 20716 USA 12. Wes Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yes ZV No If Yas, Giva Year or Dates: Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc Nevar Married 2 Married 1 ☐ Yas 2 ☐ XNo Specify: Specify 3 Widowad 4 Divorced Black 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) (Give kind of work dona during most of working lifa. DO NOT usa retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 18 Mothar's Name (First Middle Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Alexander Pye Annie Stevens 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Neme/Reletionship (Type, Print) 1319 Harrisville ROad Toms Brook, VA Norman Pye - Son 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Data 1 X Burial 2 ☐ Crametion 3 ☐ Removal from Stata River View Cemetery 8/12/00 Woodstock, VA 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Addrass of Fecility 21. Signature of Funarai Sarvica Licansee Dellinger Funeral Home 00b 157 N. Main Street 22664 Woodstock, VA Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or learn feiture. List only be cause on each line. Approximete Intarval Batwean Onsat and Deeth Immediata Causa (Final Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Ceuse (Disaese or Injury that initiated avants rasulting in daath) Last Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

the Maryla

death

72 hours after

permit. Pages 1 and 2 should be filled within 72 h. Department of Health and Mental Hygien-Important if New 27 is marked.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

d other than "natural", or thems 23s or 28s-f show event, the Medical Examiner must be notified at

physician end the buriel-transit signed by the aid be detached for peen page 2 has certificate funeral director,

The law requires that the death certificate be axecuted or Attending Physician: After this after death. the in by within 24 hours aft To the Funerei Di completely filled in Hospital

completely 6

To the

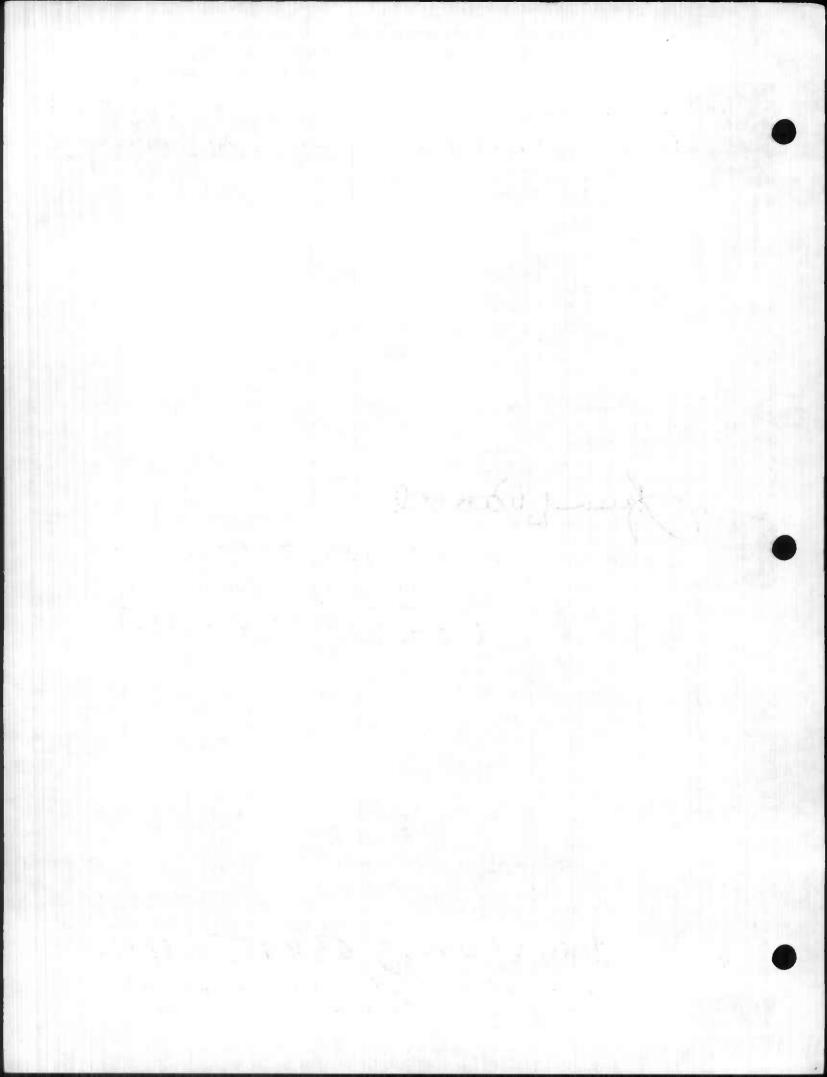
State Registrar

Certification:

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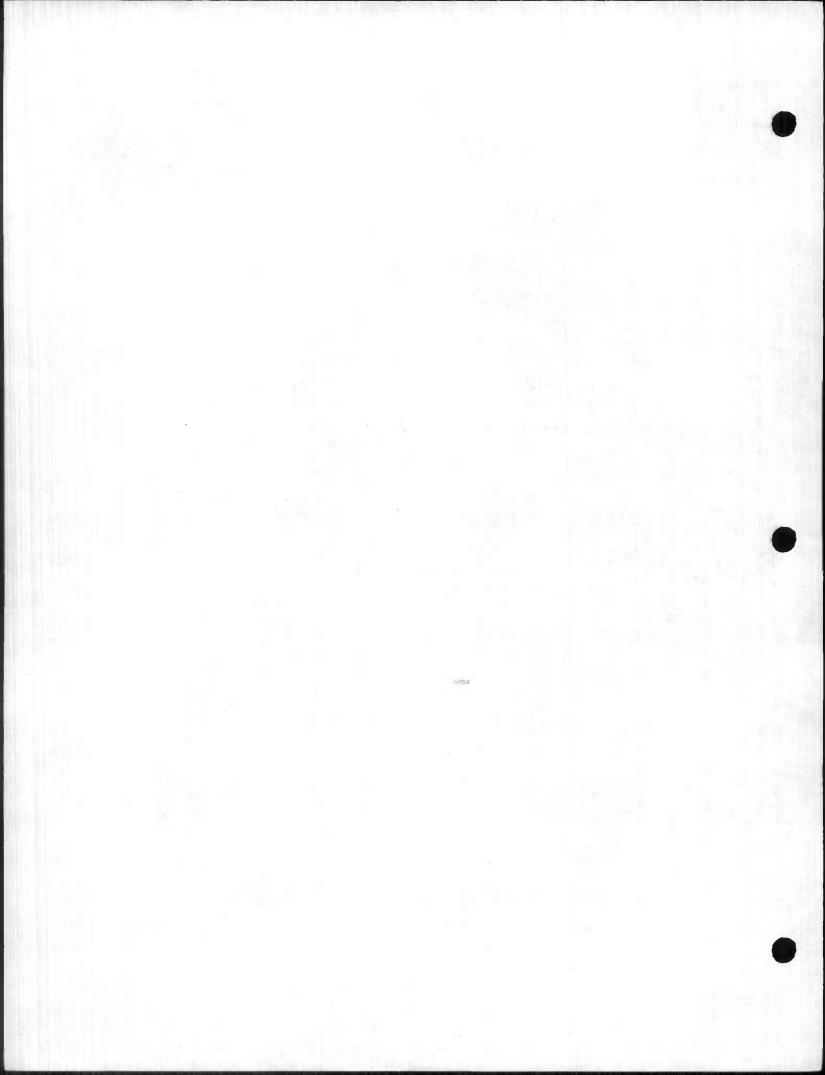
Physician/Medical p 24b. Ware autopsy findings eveilabla prior to complation of cause of daath? 24a. Was an autopsy Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarrad to medical axaminar? Be 26. Placa of Daath (Chack only one) axaminar/ 1 ☐ Yas 2 ☐ No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Xtnpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Dey Year) 1 Netural 5 Panding 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, deta and place, end due to the cause(s) and mannar as steted.
2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier 29d. Data signed (Month, Day, Year) 29b. Signatura and tha of certifian 29c. Licanse number

30. Nama and eddress of person who complated caus Colesville Road Silver Spring Hector K. Collison 8401 32. Fagistrar's Signatura 31. Date filed (Month, Day, Yaar) AUG 11



State of Maryland / Department of Health and Mental Hygiene 00 26800

					OTHITICA	te of	Deam		Reg. No.		2000:
	1. Decedent'a Name (First, Middle, La	ist)						2. Dete of De Month	eath Day	Year	3. Time of Death
an al	Ma	argareta		Pope	scu			August		000	2:05 AM
	4e Facility Neme (If not institution, giv	re street and number)				- 14	b. City, Town, o	r Location of Deal	th 4c. Cou	nty of Death	
l	Laurel Reg	ional Hosp	ital				Laurel		Prin	nce Geo	orge's
	THE STATE OF THE S	Sex 7. Ag	e (In yrs. I	Ven	(y) If Und Months	or 1 Year Deys	If Under 24 H Hours M	n. (Month, D		9. Births	lace (State or Fore
ŀ	None		74	l Yrs				June 2	4, 1926	Roma	ania
H	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or	Location					1	Od. Inside City Lim
											1 Yas 20
-	MD Prince	George's	La	urel	101. 2	ip Code			10a. Citizen	of What Cour	ntrv?
	6309 Sandy Str	00+					707		Roman		
ŀ	11. Merital Statua	12. Was Decedent		S. 1	3. Was Dec			(Specify Yea or No erto Rican, etc.)		Race - Americ	an Indian,
	1 Never Married 2 Married	Armed Forces?						erto Rican, etc.)	8	Black, White,	
	3 Widowed XXDivorced	It Yes, Give Year or Dates:			1 🗆 Yes	2 € No	Specify:		Spe	city: Wh:	ite
	15. Decedent's E			16a. De	cedent's Us	ual Occup	ation		16b. Kind of	f Business/In-	dustry
1	(Specify only highest gra Elementery/Secondary (0-12)	ede completed) College (1-4or!	5+)	(G life	DO NOT	use retired	during most of w	rorking			
1	7	Ø	.,	Т	ailor				Mar	nufacti	urer
1	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden Sur	name)	
	Achim Bunda	lescu					Victo	ria Mitc	u		
-	19a. Informant's Name/Relationship (Type, Print)		19b. M	ailing Addre	ss (Street	and Number or	Rural Route Numb	er, City or To	wn, State, Zip	Code)
1	Nicoleta Paltinea	nu /Daughte	30	630	Q San	3v St	root. I	aurel, M	arvlano	a. 207	7
	20e. Method of Disposition		20b. P	ace of Di	sposition (N	errie of		Date	20c. Locatio	on - City or To	own, State
	XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				Washi			8/17/00	Adelph	ni. MD	
-	21. Signature of Funeral Service Lice			Lyc				Donaldso			mo D A
ı	1 Jamino	Not 1			212 m	albot		e, Laure			ile, F.A.
+	22a Part Friday to discourse	1/allemol		Donat						20707	Approximete
	23a Part Frier the disease, or com shock or heart failure. List only	one ceuse on each li	ne.	i. Do not	oritor tiro iii	o or ayn	ig, soon as care	ac or respirotory	arrost,		Interval Between Onset end Deeth
1	Immediate Cause (Final										
П	disease or condition resulting In death)	a. CVA	1								10 Days
5			Due to (or	ras a con	sequence of):				1	
		b. Ser	sis	116.7							
Î	Sequentially list conditions, if any, leading to immediate		Due to (or	as a con	sequence of):				1	
	Cause (Diaease or Injury	c									
	thet initieted events resulting in death) Last		Due to (or	es e cons	sequence of):				= 1	
	DOMESTIC LINES	d									
1	Part II. Other algnificant conditions of	contributing to death b	ut not resu	ilting in th	e underlying	cause giv	en in Part I.				o the cause of dea
	Diabetes	Mallitus						1	Yee 210 N	o 3 Pro	bably 4 🗆 Unkn
								24a Wa	s an autopsy	24b. W	ere autopsy finding
									ormed?	av	allable prior to empletion of cause
									VV		deeth?
								4 🗆	Yes XX N	0 11	☐ Yea ŽŽ No
								- '-	100 ECSIV		
	25. Was case referred to medical examiner?	Marshall				000		eath (Check only			
	examiner? 1 Yes 2XXIII	Hospitel: XXInpatie		ER/Outpa			er: 4 Nursing	Death (Check only Home 5 Res	one)		5/)
	examiner?	Hospitel: Manpatie 28a. Date of Inju		ER/Outpa 28b. Tim Injur	e of y	28c. Injur Wor	er: 4 Nursing	Death (Check only Home 5 Res	one)		(y)
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				icate of	Death		Reg. No.	Los		
Physician	Decedent's Neme (First, Middle, Last MARY THERESA I	ROBINSON				2. Dete of De Month Augus	Day	2000	3. Time of Death 9:30 AM	
/Medical	MARY THERESA I	4	lb. City, Town, or Lo				7.30 241			
Examiner	4545 Banner Stree					Brentwood Prince George				
Funeral Director	5. Social Security Number 6. Se 579–56–4841			Under 1 Year onths Deys	Hours Min.	8. Dete of Bir (Month, De Nov. 13			lace (Stata or Foreig try)	
the of the	Usual Residence of Decedant 10a. State 10b. County	10c. Cit	ty. Town or Location	on					0d. Inside City Limits	
or 28a-f show a notified at	Maryland Prince G	eorge's No	rth Bren	twood					1 Yas 2 □ No	
or 28s-fr be notifie Directo	10e. Street and Number		1	Of. Zip Code			10g. Citizen of V		try?	
2 - A L	4545 Banner Stree	t	100	20722			U.S.A	•		
urn after death with the Marylar at, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Detas:	If Ye	Decedent of H s, specify Cube Yes 2K No	lispanic Origin? (Spe sn, Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)		a - Americ k, White, o		
ed within 72 hours ypiere. er than "natural", it, the Medical Exa Completed by	15. Decedent's Edu (Specify only highast grad		16a. Decedent' (Give kind	s Usuel Occup of work done	during most of worki	16b. Kind of Business/Industry				
sello Ban Da Ma	Elementery/Secondery (0-12)	College (1-4or 5+) 1 Year			, pecialist		Govern	nment		
	17. Father's Neme (First, Middle, Last)	Treat	ZHZ OZ MO		18. Mother's Neme	(First, Middle				
Mental H Mental H inhed off affic even To Be	Calvin Johnson				Christin	ne Joh	nson			
d 2 show	19e. Informent's Name/Relationship (T) Sylvester Robinso				and Number or Rure					
Healt Healt Hem Z other	20a. Method of Disposition	20b. F	Plece of Dispositio	n (Name of		Dete	20c. Location -			
semil. Pages 1 a Department of Hea Incortant: If Item Inty Injury or othe IDSB.	1 ☐ Buriel 2 ☑ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	temovel from Stete	verdale I		111	8/08 000	Riverda	le, M	faryland	
pemil. Departrimporta eny inje	21. Signature of Funarai Service Licens	oo +.			ss of Fecility INS FUNERA			evlan	a 20785	
	23a. Pert 1. Enter the disaese, or compleshock, or heart feiture. List only of	ications thet caused the daat ne ceuse on each line.	th. Do not entar th	e mode of dyin	ig, such as cardiec o	r respiretory	orrest,	Lylan	Approximate Intervai Between	
Physician /Medical	Immediete Cause (Final	Liver Fail	ure					1	Onsat and Death 1 month	
Examiner	diseese or condition resulting in deeth)	9	or es a consequen	ce of):						
i d		Metastatis	Colon C	ancer					(3 Months	
physician and street street but and street but all transit	Sequentially list conditions, if any, leeding to immediate			4						
physicia the bur	cause. Enter Underlying Cause (Diseese or injury thet initieted events									
	resulting in death) Lest	75.7								
ath for for								I		
the the	Part II. Other aignificant conditions con	ntributing to deeth but not ras	sulting in the under	tying cause giv	ren in Part I.				the cause of death	
5 50						1	Yea 2□No	3 Prol	bably 4 € Unknow	
been s should						24a. Wes	s en autopsy ormed?	ev.	ere autopsy findings alleble prior to mpletion of causa deeth?	
The law ate has page 2						10	Yes 2⊠No	10	Yes 2□ No	
certificate rector, pag	25. Wes case referred to medical examiner?				26. Plece of Deeth	(Check only	one)			
Z 50 5	1 Yes 2⊠ No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient	DOA Oth	er: 4 Nursing Ho	me 5 Res	idenca 8 □Oth	er (Specif	y)	
After fune	27. Menner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ No	28d. Describe	how injury occur	red		
Parit I	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h building, etc. (Specif			(Street and Numb wn, State)	er or Rura	I Routa Number,			
To the Hospital or Attention within 24 hours after dealt To the Funeral Director: completely filled in by the Medical Certifical	29e. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my kno ner: On the basis of exemina and menner steted.	owledge, deeth occation and/or investi	curred et the tir igetion, in my c	ne, date end piece, opinion, deeth occurr	end due to the ed et the time,	cause(s) and me dete end place,	enner es s and due to	tated. o the ceuse(s)	
within To the comple	29b. Signeture end title of certifier			29c. Licens	e number		29d. Dete signe	d (Month,	Day, Year)	
F 5 F 0	1/1	7/6	01	D-359	196		August	8, 20	000	
(10)	30. Name end address of person who co Linda Burrell, M	ompieted cause of deeth (Iter .D., 2730 Uni	m 23e) (Type, Prin Versity	Blvd We	st, #400,	Silve	r Spring	, MD	20902	
State	31. Dete filed (Month, Day, Year) AUG 0 9 2000	32. Registrar's Signe		ness!						

DHMH 16 Rev 6/95

1000 200 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 2000 Month 11:05 PM August Jay D. Ray, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) HRundel rospita ien Burnic Anne HRundel If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | March 2, 1 5. Social Security Number Yn vrs. last birthdev) Birthplace (State or Foreign Country) 7. Age 1 M 2□ F Months 63 235 58 9697 Yrs. West Virginia Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ZENo Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8242 Riviera Drive 21144 United States 12. Was Decedent Ever in U.S. Armed Forcas? ¾∑ Yes 2 □ No ff Yes, Give Year or Dates:3/56 9/56 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Coffee Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Jay D. Ray, Sr. Alma V. Scritchfield 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Wife Joyce L. Ray 8242 Riviera Drive Severn Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) August 7, ale 2000 20c. Location - City or Town, State 20a. Method of Disposition PORBurial 2 ☐ Cremation 3 ☐ Removal from Stete Maryland Veteran Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Maryland 22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Onset and Death Perforated Pyloric Ulcer Immediata Cause (Final disaasa or condition resulting in death) Disseminated Intravascular Coagulation Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury Que to (or as a consequence of): that initiated events resulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of seath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1□ Yes 2 No 21 No 1 Yes 25. Was cese referred to medical 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Menger of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medical Examiner The law requires that the death certificate be executed 68760. Box P.0. of Vital Records, by Be Completed certificate has page I or Attending Physician: " after death. Director: After this certifica 10 Division within 24 hours a to the Funeral C for the Hospita

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

Norms 23s or

nd Mantal marked or should be

and a

Health Hem 27

Physician

/Medical LAdifficien

Baltimore, Maryland 21215-0020

Medical Certification:

State Registrar

AUG 0 8 2000 **DHMH 16 Rev 6/95**

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) George E, Wicks TE M.D., 301

With IT M.D.

32. Registrar's Signature

ORIGINAL

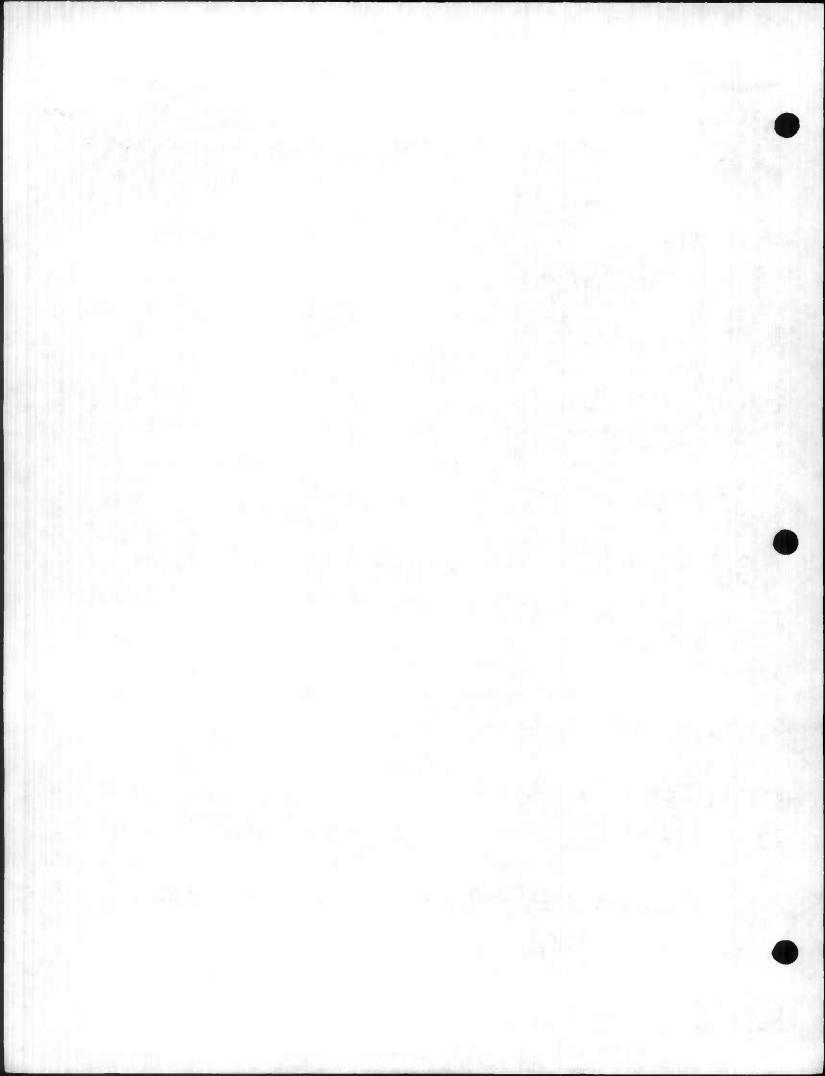
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

301 Hospital Drive, Glen Burnie



State of Maryland / Department of Health and Mental Hygiene 00 268 | 2

			C	ertifica	te of	Death			Reg. No.				
A R LE	1. Decedent's Name (First, Middle, Las	()						2. Data of De			3. Time of Death		
Physician	Gaetano Frank Rizzo								Month Day Year August 3, 2000				
/Medical	Ab City Town of A												
Examiner									LLE MONTGOMERY				
	SHADY GROVE ADVENTIST HOSPITAL ROCKVII 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs.												
Funeral	11	XIM 2DE		Months	Days	Hours	Min.	8. Date of Bit (Month, Da	y, Year)	Cour	plece (Stete or Foreigntry)		
Director	Usual Residence of Decedent	9	4 4					Sept.	23, 1905	New	iork		
P	10a. State 10b. County	10c.	City, Town or	Location							IOd. Inside City Limits		
and and a											1 X Yes 2 □ No		
r 28a-f sh notified frector	Maryland Montgome	ery	Gaither										
or 28s-f : or 28s-f : os notifies	10e. Street and Number			10f. Z	ip Code				10g. Citizen of V	/hat Cour	ntry?		
23a or wat be until	415 Russell Avenue	± #818		2	0877				United	Stat	es		
S 5 90	11. Maritai Siatus	12. Was Decedeni Ever i Armed Forces?	n U,S. 1	3. Was Dece	edent of H	ispanic Ori	gin? (Spa	cify Yes or No Rican, aic.)	- 14. Race	- Americk, White,	cen indian,		
P. P.	1 ☐ Never Married 2 № Married	1⊠Yes 2□No l	944-	1 ☐ Yes		Specify:	, , , , , , , ,				010.		
D E .	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	946	ILI Tes	2 128 140	Specify.			Specify		ite		
naturi riaturi dical	15. Decedent's Ed	uceiion	16a. De	cedent's Usi	ual Occup	ation			16b. Kind of Bu	-			
T in 7	(Specify only highest grad		(G	ive kind of w e. DO NOT	ork dona use retired	during mosi 1)	of works	ng					
ed within	Elementery/Secondary (0-12)	Coilege (1-4or 5+)	Acco	ountan	t				Naval M	edic	al Center		
	17. Father's Neme (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden Surnam	e)	VIII VIII		
Sales e													
To Man To	Salvatore Frank Ri				101			*	Salerno	0 7:	. 0. 4.1		
O Band	19e. Informant's Name/Reletionship (7								er, City or Town,				
and n 27 Mer tr	Dorothy Mae Rizzo						#818		hersburg				
- 10 mg	20a. Method of Disposition 1888uriai 2 Cremation 3	Domewal from Chala	b. Place of Di cemetery,	sposition (Ne cremetory or	other plac	ce)	İ	Date	20c. Location -	City or To	own, Stata		
Pag Pag	4 Donation 5 Other (Specify		arklaw	n Memo	orial	Park	8	/5/00	Rockvil	le, l	Maryland		
in ports	21. Signature of Funeral Service Licens								neral Ho	-			
Page 18	1 R 1.+ 2	000	7	10 Eas	st De	er Pa	rk D	rive					
	Noone X	- helof	4	Gaithe	rsbu	rg, M	D 20	877			Autonologica		
	23a. Part1. Enter the disease, or composhock, or heart failure. List only of	one cause on each line.	leath. Do not	enter the mo	oe or dyli	ig, such as	cardiac	respiratory a	irrest,	1	Approximate interval Between Onset and Death		
Physician			1		11		1	1	C 1	1	- 1		
/Medical Examiner	Immediate Cause (Final disaasa or condition	. Acute a	interio	or wo	illi	MINI	ard	ial i	ntarctio	n	2 days		
	resulting in deeth)	Due	o (or as a con	sequence of):	7							
D = 5		, Sick.	Sinus	SIL	n dra	me					4 years		
executed in and faltransit	Sequentially list conditions.	U	o (or as a con										
EX Tall	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury c.												
certificate be executed right physician and use as the burlal-transit nVM edical Examir	Cause (Disease or injury that initiated events												
ed the	resulting in death) Last	,.											
nding p use es		d											
atte atte													
ys l	Part If. Other significant conditions co	tributing to death but not resulting in the underlying ceuse given in Pert I.						23b. Did tobacco use contributs to the cause					
that the ed by detac	Pacemaker							1□	Yes 25 No	3□ Pro	bably 4 Unknow		
2 88 2													
v requires been sign should be									s en autopsy ormed?	av	ere autopsy findings vallable prior to		
law re as be 2 sh							_			ot	ompletion of ceuse death?		
The lay sate has page 2								10	Yes 2500	1	□ Yes 2□ No		
icati	OS Man ages referred to medical						4.5				2,00 2,00		
ysician: The s certificate director, pag To Be Co	25. Was cese referred to medicel examiner?	Hospital: A	_		Ott	er.		h (Check only					
2 00	TEL TOS ZENO	1 Lyinpaliant	2 ER/Ouipa		JUA	4LIN	-		idence 6 Oth		ify)		
After funer funer	27. Manner of Death 1 25 Netural 5 ☐ Pending	28a. Date of Injury (Month, Dey Yea	r) 28b. Tim fnju	ry	28c. Injur			280. Describe	how injury occur	ed			
Attending or death. octor: After the fune by the fune iffication	2 Accident investigation			М	1 🗆	Yes 2	No						
Let or Attending P rs after death. In Director: After it ed in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Place of fnjury - / building, etc. (Sp	At home, farm	, street, facto	ory, office			28f. Location	(Street and Numb	er or Rur	ral Route Number,		
din din		ounding, oto. (op	ouny)										
Hospit 4 hour Funer tely fill	(Check only 2 Medical Exam	velctan: To the best of my	knowledge, de nination and/o	eath occurre r invastigatio	d at the tir	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time	cause(s) and ma , date and place,	nner as s	stated. to the cause(s)		
within 2 To the comple	One)	and manner stated.			On Linear	o numba-			20d Deta elec-	d /Manth	Ony Vand		
O T X T O	29b. Signature and title of certifier	1				e number			29d. Daie signe				
5+1	Cullion	alle , M)			1)	1277	7	Co. C.	+ugus+	13,	2000		
	30. Name and address of person who d	completed ceuse of death (pe, Print)			0	11	Augustanylad 2	1.4.			
	Richard Washs	ten 15225		4 Gran	re Roi	nd 1	Kack	nle, M.	aylad 2	083	50		
State	31. Date filed (Month, Day, Year)	32. Regisirar's S	771-										
State	AUG 0 7 20	non Bener	_	1	"	1							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dey Month **Physician** August 5, 2000 James William Root, Sr. 4:00 pm /Medical 48 Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days 93 Yrs. 577-05-3587 September 10, 1906 Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director 28a-f Chevy Chase Maryland Montgomery must be notifie 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? b Berns 23a 2708 Colston Drive 20815 United States 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Merifel Status Black, White, etc. 1 Never Merried 2 Married "natural", or Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygians. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager/ Film Broker Motion Film Industry pomit. Pages 1 and 2 should be file Disparment of Health and Meinal Hy Importants if then 27 is marriad othe any Injury or other traumatic event once. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be William Alexander Root Marguerite Louise Yates 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 17209 Spates Hill Road Poolesville, Maryland 20837 Russell B. Root/ Son 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ABurial 2 □ Cremetion 3 □ Removel from State August 4 ☐ Donation 5 ☐ Other (Specify) 9,2000 Cedar Hill Cemetery Suitland, Maryland 21. Signature of Funeral Service Licenses Robert A. Fumphrey Funeral Home/ Bethesda-Chevy Chase 1nc 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00335 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such a sea rdiec or respiretory arrest, shock, or heart feilure. Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical equ for use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown bengis Š Records. 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 s 8 5 2000 Outain R 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 24 hours after death. • Funeral Director: After 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my trop ledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of example tion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of 6 and must be trained. 29b. Signature aga title of fertifier 29d. Date signed (Mostin, Day, Year) 10 30. Name i ed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Ray 6/95

State

Foster . M.D.

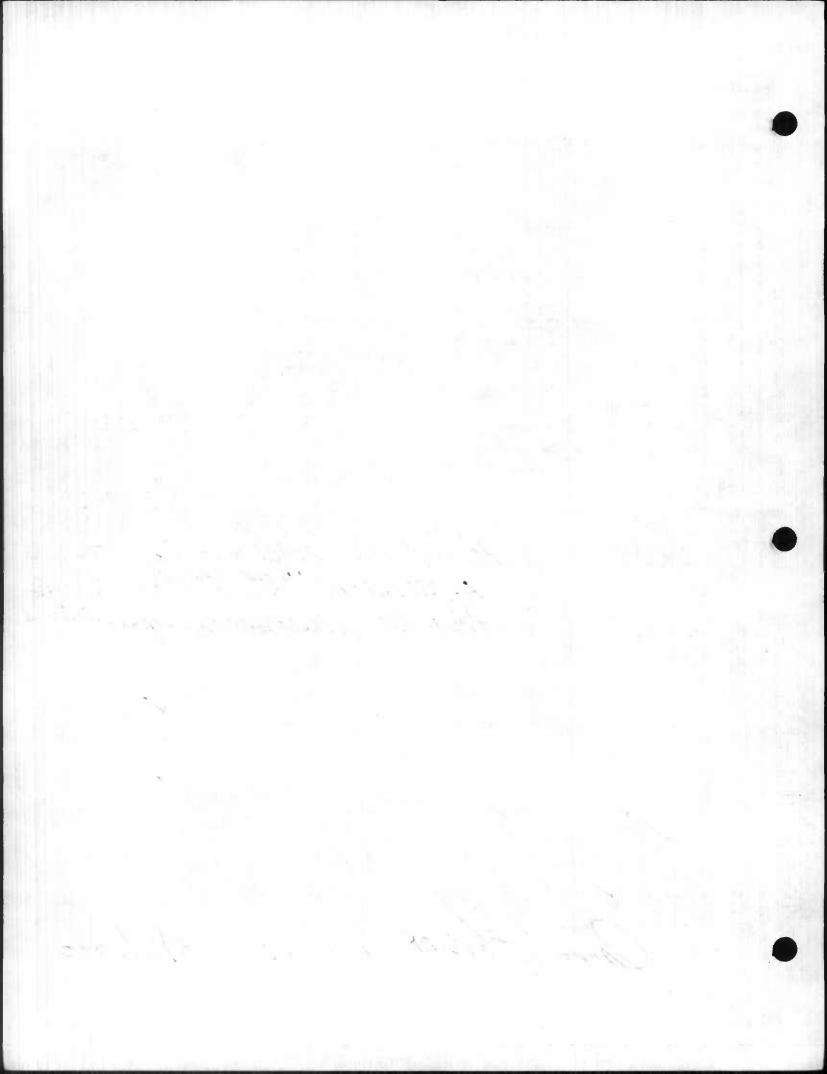
James J.

31. Date fifed (Month, Day, Year)

AUG 0

32. Registrar's Signeture

5530 Wisconsin Avenue #925 Chevy Chase, Maryland 20815-4330

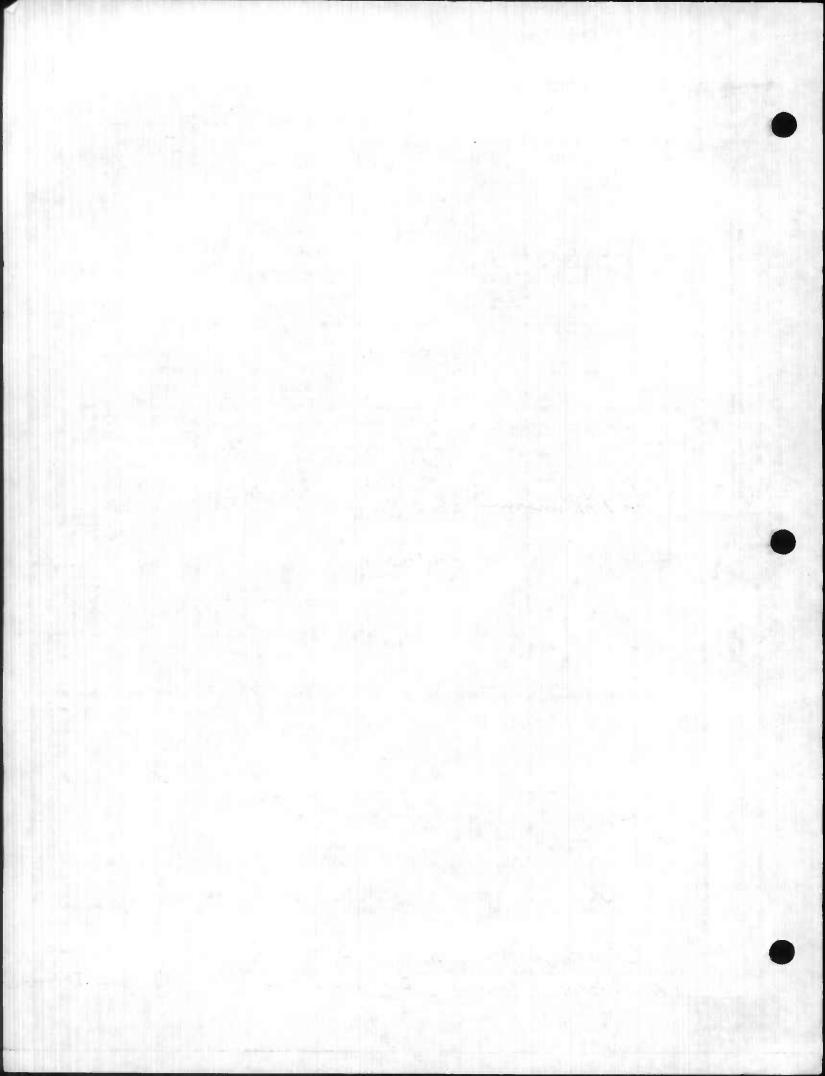


State of Maryland / Department of Health and Mental Hygiene

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			(Certificate	of Deat	h	Re	g. No.	20014			
A STATE OF	1. Decedent's Name (First, Middle, Le	ist)					Date of Death		3. Tima of Death			
Physician	Frederick	0.	Rost	t			ugust	6, 200				
/Medical Examiner	4a Facility Neme (If not institution, gir	re street and number)	H-FM	1000	4b. City,	Town, or Location	n of Death	4c. County of D				
	Brookgrove Nursi	Montgo	mery									
Funeral Director		KIN OFF	rs. last birth	day) If Under 1 Months	Year If Und Days Hours	s Min. Dec	Date of Birth Month, Day, cember	Year) 9. 22,1911	Birthplece (Stete or Foreign Country) NY			
7.	Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d.											
Merylan e-f show iffind at	MD 10b. County MD Montgo			Spring					10d. inside City Limits 1 ☐ Yes 2 📉 No			
or death with the Maryla thems 23e or 28e-f shor ner must be motified at uneral Director	10e. Street and Number 18430 Brooke Gro	ve Road		10f. Zip C	2086	0	10	og. Citizen of What USA	,			
	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: WW		13. Was Decede If Yes, specif	ent of Hispanic (fy Cuban, Mexic No Speci		Yes or No- n, etc.)		umerican Indian, White, etc. white			
ted feet	15. Decedent's E		16a. [Decedent's Usual	Occupation	oet of working	1	16b. Kind of Busine	ass/industry			
ad within 72 ho wer than "nature or than "nature t, the Medical Completed	(Specify only highest grave Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work life. DO NOT use ctricia:		lost or working		Construct	tion			
May yielly a fire 15-10-00-00 02 should be filed within 72 hours at 02 should be filed within 72 hours at 03 should be filed "Medical Examp To Be Completed by 8	17. Father's Name (First, Middle, Last Joseph Rost)			18. Mo		feiden Sumame)					
Marry of 2 shou th and M 27 is ment traumant	19a. Informant's Name/Relationship			Mailing Addrass (•			City or Town, State	te, Zip Coda) 0777			
Coffies (of Heam) or other	20e. Mathod of Disposition 1 Burial 2 X Cremetion 3	Removel from State	cemetery	Disposition (Nemo, crametory or oth	her place)	Aug	ust	20c. Location - City				
Destrict Pa Chpartmen Important: any Injury once.	Chesapeake Crematory Inc 8, 2000 Beltsville, 22 Name and Address of Facility Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 20910											
b	23a. Part1. Erftar the disease, or com shock, or heart failure. List only	aplications that caused tha do one cause on each line.	eeth. Do no	933 Gi	of dying, such	, Silve as cardiac or res	r Spri	ng, MD	Approximate Interval Between Onset and Death			
Physician	Immediate Cause (Final											
/ /Medical Examiner	disaase or condition resulting in death)		JUSIS									
MENTAL 5	Due to (or as a consequence of):											
death certificate be executed eatherding physician and of for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or injury	b. — Dua t										
	thet initiated events resulting in death) Last Due to (or as e consequence of): d.											
at the death certified by the attending etached for use a Physician/M	Part II. Other significant conditions	contributing to death but not	resulting in	the underlying ca	use given in Pa	irt I.	23b. Did tobacco use contribute to the co					
									Probably 4 Unknow			
requirements been seponded							24a. Was ar perform		4b. Were autopsy findings svallable prior to completion of cause of death?			
							1 □ Y6	s 22 No	1 ☐ Yes 2 ☐ No			
certificate irector, pag	25. Was case referred to medical				26. Pl	ece of Death (CI	heck only on	Θ)				
Physician: this certific ral director.	axaminer? 1 ☐ Yes 2 ☐ No	Hospitel:	2 ER/Outp	patient 3 DOA	Other			nce 6 Other (Specify)			
2 2 2	27. Manner of Death 1 Natural 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Dey Yea			Sc. Injury at Work?	28d.		w injury occurred				
tal or Attending P is after death. al Director: After tied in by the funers Certification:	3 Suicide 6 Could not be detarmined	28a. Place of Injury - A building, atc. (Sp	At homa, farr	m, street, factory,	office	28f.	Location (St. City or Town	reet end Number o	or Rurel Route Number,			
To the Hospital or within 24 hours after To the Funeral Director completely filled in Medical Cert	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nyelcian: To the best of my niner: On the basis of exam and menner stated.	knowledga, nination and	death occurred at for invastigation, i	t tha time, data in my opinion, c	and place, and death occurred a	dua to tha ca t the tima, da	ause(s) and manna ate and place, and	ir as stated. dua to tha cause(s)			
Vithin Co the complex of the complex	29b. Signature and fitle of certifier			29c.	License numbe	9r	2	9d. Dete signed (N	fonth, Day, Year)			
01	· Classes	sl pay	0	_	1397	793	A	trjust	7,2000			
	30. Name and address of person who	completed cause of death (Itam 23a) (T	ype, Print)	Dan u	us 2	902	clristo	John Day, Year) 7, 2000 Jeer J. Klerys			
State Registrar	31. Dete filed (Month, Day, Year) AUG 1 0 2	32. Registrar's Si	igneture	9. Spo	uls							

10



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** August 9, 2000 Margaret Virginia Shipley 11:38 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country)
Aug. 15, 1923 Washington, DC 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Months Days Hours Yrs. 577-48-4691 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show 1X Yes 2 No Directo Maryland Silver Spring Montgomery 10e Street and Number 10f. Zlp Code 10g. Citizen of What Country? 'natural', or flams 23s or than "natural", or items 23s or the Medical Examiner must be. 1135 University Boulevard 20902 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ₺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: by 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filled within Elementary/Secondary (0-12) College (1-4or 5+) 10 Cashier Pharmaceutical Co. Hyd 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental Mental is marked Thomas Lowell Anderson Eva Gertrude Sly 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an ant: If Hem 27 is r Audrey M. Richey - Daughter 7643 Laytonia Drive, Gaithersburg, MD 20877 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from Stata Cedar Hill Cemetery 8/12/2000 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Gasch's Funeral Home, P.A. letted. 4739 Baltimore Ave., Hyattville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Pulmonary Embolus Day **Examiner** Due to (or as a consequence of): Physician/Medical Examiner 2 Days Deep Vein Thrombosis The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician and deteched for use as the burial-tran Box 68760, Congestive Heart Failure 1 Week Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detect 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Chronic Obstructive Pulmonary Disease Division of VItai Records. by 24b. Were autopsy findings available prior to completion of cause of death? if or Attanding Physician: The law require effer death. Director: After this certificate has been six d in by the funeral director, page 2 should t 24a. Was an autopsy Completed 2 X No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifler (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10,2000 ver mp 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter B. Sherer, M.D., 3921 Ferrara Drive, Wheaton, MD 20906

DHMH 16 Rev 6/95

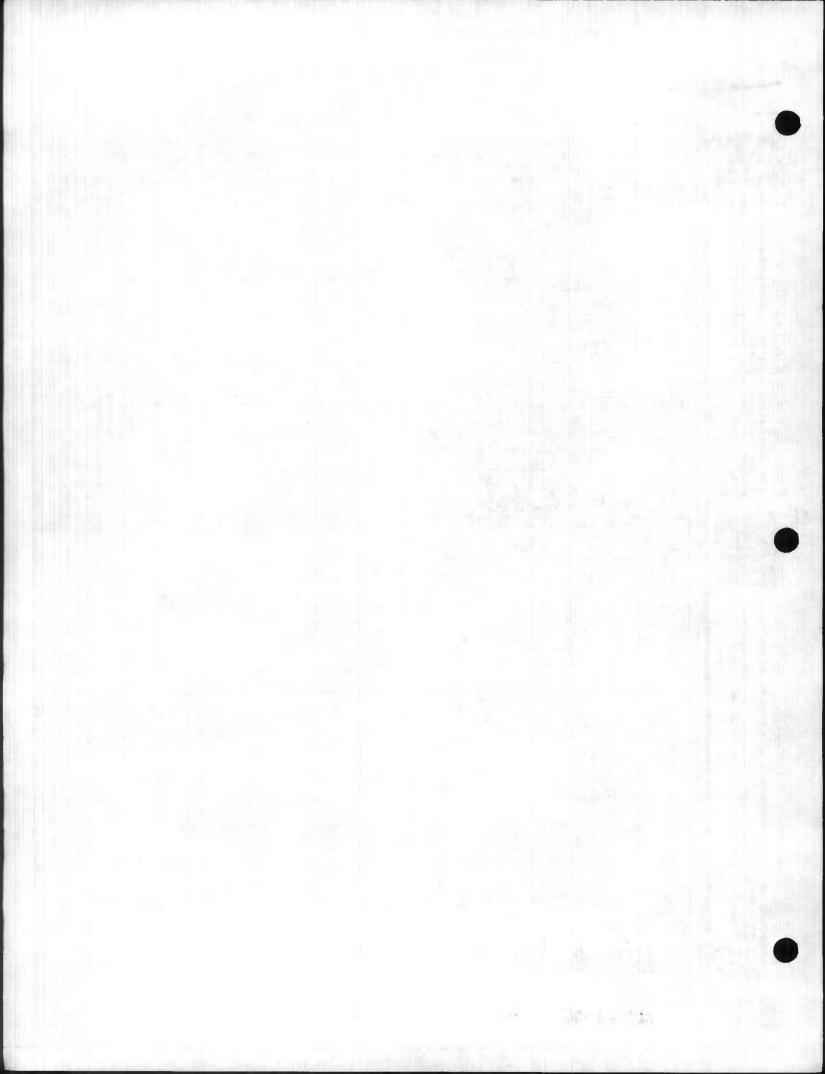
State

Registrar

31. Data filed (Month, Day, Year)

AUG 1 1 2000

32. Registrar's Signature



WALTER THOMAS SAVOY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) **Physician** Savov 6, 2000 AUG. 1902 PM /Medical 4a Facility Name (If not Institution, give street and number)
FORT WASHINGTON HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) XX M 2□ F **Funeral** 214-42-6206 Yrs. 54 Director May 19, 1946 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Bryans Road Director Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20616 6850 Arbor Lane "natural", or itsms 23a Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status filed within 72 hours after 1 Never Married Married American 1 Yas PNo Specify. Baltimore, Maryland 21215-0020 л Yes, Give Year or Dates P 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry than Elementary/Secondery (0-12) College (1-4or 5+) Construction Plumber 7 is marked other traumatic event, it 18. Mothar's Name (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Nem 27 is marked oth any linjury or other traumatic event page. 17. Father's Name (First, Middle, Last) Be Mary G. Swann William A. Savoy, Sr. 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6850 Arbor Lane, Bryans Road, Maryland 20616 Lillian D. Savoy (WIFE) 20a. Method of Disposition

XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of camatary, crematory or other place) Aug 11, 2000 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Josephs Catholic Ch Cemetery Pomfret , Maryland 22. Name and Addrass of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Sarvica Licensas Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) **Examiner** Due to (or as a consequenca of) Physician/Medical Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760 that initiated events resulting in death) Last Dua to (or as a consequence of): signed by the a P.O. 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DO No 3 Probably 4 Unknown 1 Yss þ of Vital Records, 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? Yes 2 No 127es 2 No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 2 Accident 806 1 Yes -rinou Do accido 400 IVe 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide RIE. LIVING STON PSD edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. one) 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifian O.C.M.E AUG. 7, 2000 e and address of person who completed cause of death (ttem 23a) (Type, Print) ND 111 Penn Street, Baltimore, Maryland 21201 1 0 2000 31. Date filed (Month) 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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					Ce	runcate	OIL	realli		Reg. No.				
	1. Decedenf	s Neme (First, Midd	dle, Last)						2. Date of De Month	Day	Yaar	3. Time of Death		
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xaminer	4e Facility N	ame (If not institution	on, giva street en	d number)			4b	. City, Town, or L	ocation of Deat	Death 4c. County of Death				
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Director				- 9 -	1									
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Ö	17. Father's	Neme (First, Middle	, Last)					18. Mother's Nem				3		
o Be			d Shie	lds				Jean	ette I	raughn				
To		ent's Name/Reletion	shin (Type Prin	*)	19h Mail	ing Address /	Street e	nd Number or Ru	rel Route Numb	er. City or Town.	Stete. Z	in Code)		
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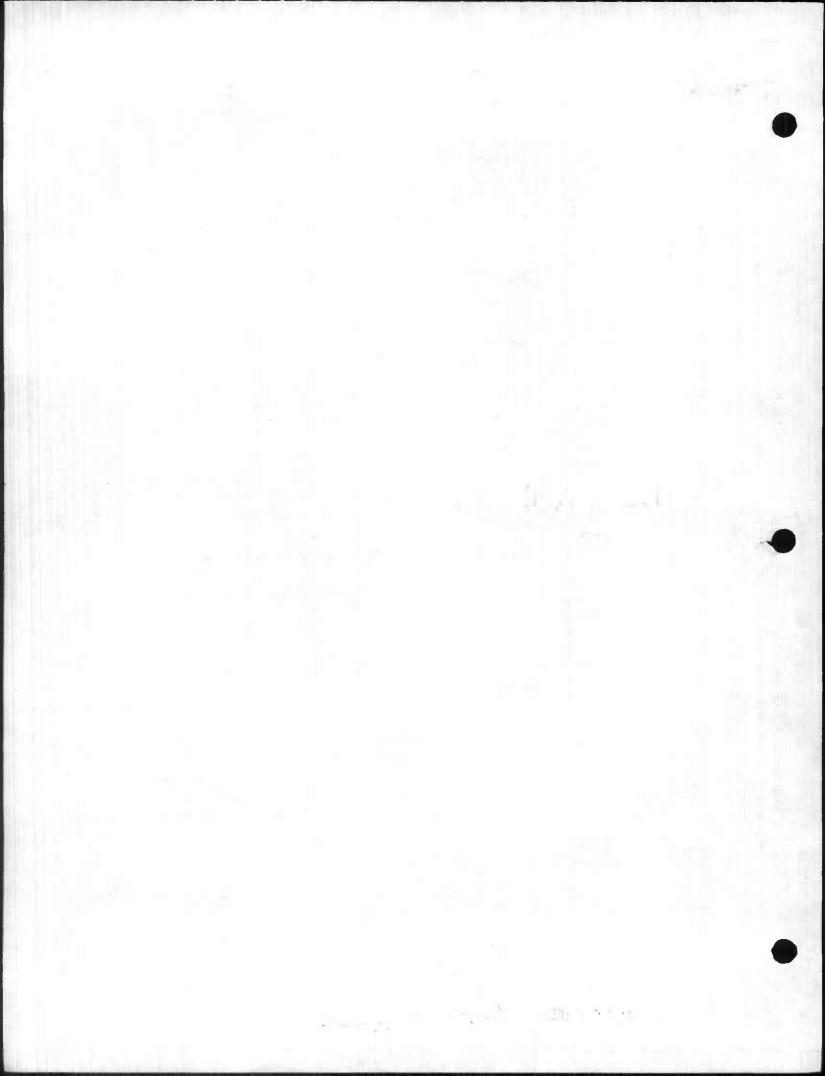
State of Maryland / Department of Health and Mental Hygiene 00 26818

			Ce	rtificate of	Death			Reg. No.	-		
Physician	1. Decedent's Name (First, Middle, Li	nsf)				2.	Date of De Month	eath Dey	Year	3. Time of Death	
Physician /Medical	Ruby D. Sutt						Augus		000	10:50 P.M.	
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Funeral Director		Sex 7. Age (I 1 M 2√E√F	n yrs. last birthday, 83 Yrs.	Months Days		Min.	Date of Bir (Month, Da	th ly, Year) 9, 1916		place (State or Foreign htry) th Carolina	
9 2	Usual Residence of Decedent 10a. State 10b. County	14/	Oc. City, Town or Lo	ocation					1	Od. Inside City Limits	
earn with the Maryla we 23e or 25e-f show must be notified at eral Director	North Carolina	Lenoir	Deep Ru							1 Tes No	
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rai rai	2409 Liddell Roa			285				United			
r liter niner.	11. Marital Status 1 Never Married 荃图 Married	12. Was Decedent Eve Armed Forces? 1 Yes 22 No If Yes, Give		Was Decedent of If Yes, specify Cuit 1 ☐ Yes ★▼ No.			y Yes or No an, etc.)	Blac Specify	k, White,	ean Indian, etc. 11te	
Exa d by	3 Widowed 4 Divorced	Year or Dates:		T. A.					****		
t. the Medical Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retir	ipation e during mos ed)	st of working		16b. Kind of Bu	isiness/In	dustry	
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It's even To Be	17. Father's Name (First, Middle, Las Furney Davenpor	•				ers Name (Fi nel Tyr		, Maiden Sumam	e)		
traum	19a. Informant's Name/Relationship		0100	ing Address (Stree				N.C. 28		Code)	
94	Thomas A. Sutton 20a. Method of Disposition	, Sr. Husban								own, State	-
6 # 6	1 ☐ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Disponentery, cre	matory or other pl	ace) Au	igust 8	3, 200	00			
ng a	4 Donation 5 Other (Special Service Lice		Deep Run	Preewil.	L Bapt	ist Ch	nurch	Cemetry	Deep	Run N.C.	_
any	1 Don't 6	Sigim		2. Name and Add Obert E.							
	23a. Palt1. Enter the disease, or con	. Curi.		6000 Ann					nd 20	O715 Approximate	_
	shock, or heart failure. List only	one cause on each line.	e death. Do not en	iter the mode of dy	nng, such as	s cardiac or re	aspiratory a	urest,	1	Intervel Between Onset and Death	
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Be C	25. Wes case referred to medical				26. Plac	ce of Death (C	Check only				-
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5 7	27. Manner of Death	28a. Date of Injury (Month, Dey Y	28b. Tima o					how Injury occur		Home	
e fune atlon	1 Natural 5 Pending 2 Accident Investigation		ear) Injury		☐Yes 2☐	No No					
To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	3 Suicide 6 Could not learnined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	treet, factory, office	9	28f		(Street and Numb wn, State)	er or Run	al Route Number,	-
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To the Funeral Direct completely filled in by Medical Certifi		hysician: To the best of n miner: On the basis of ex and manner stated	amination and/or in								
M M	29b. Signature and title of certifier	,		29c. Lice	nse number			29d. Date signe	d (Month,	Day, Year)	
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12/	30. Name and address of person who	completed ceuse of deat	h (Item 23a) (Type	, Print)	75						-
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State	31. Date filed (Month, Dey, Year)	32. Registrar's							M	IVER-03L	7
Registrar	AUG 0 9 2000	Celevi	19.	Spark	/						

585 P. g. Sec.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Hugust Day Year **Physician** Lula Elizabeth Smith 08.30 3 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 6 lenarder Dellwood Drive Georges If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Sept 25,1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2⊠ F Hours 577-38-2972 71 Yrs. Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits show Prince George's 1 Yes 2 □ No must be notified Director Glenarden 28a-f 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ò 7940 Dellwood Drive U.S.A. 20706 Berns 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Nevar Married 2 Married Black Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: à 3 ∰Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secon 10th condary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If New 27 is marked on any Injury or other Be Pages 1 and 2 should be Harry Lewis Geneva Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4231 Bar Harbor Place Bowie MD 20720 19a. Informant's Name/Reletionship (Type, Print) Toni Jean Smith-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8-10-00 Harmony Memorial Park Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785 Tercen e, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, List only one cause on each line. 23a. Part1. Enter the disage shock, or heart failure Approximete Interval Between Onset and Deeth **Physician** Atherosoferotto Candiovascular Disease Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner attending physician and for use as the bunal-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 2 Onknown 2 Dinbetes 1 Yes 2 No signed to Records, P 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics stely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? 1 ☐ fes 2 ☐ No Other: 4 Nursing Home 5. Hesidence 6 Other (Specify) Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 -Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital of within 24 hours at To the Funeral D completely filled? 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29c. License number 29b. Signature and title of certifiar 29d. Date signed (Month, Day, Year) 140055929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (10 Cheverly, Maryland 20785 3001 Hos Sylvest gr 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 9 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26820 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 31, 2000 Physician 4:45AM RIDGWAY P. SMITH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CHEVERLY PRINCE GEORGES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth SEPT 8, 1912 9. Birthplace (State or Foreign Funeral Days Months Hours Min. 1 ☑ M 2 ☐ F NEW"YORK 224-52-1559 87 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No ALEXANDRIA Director VIRGINIA FAIRFAX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 22307 6238 RADCLIFF ROAD 12. Was Decedent Ever in U,S. Amed Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 6 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE À 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. Elementary/Secondary (0-12) College (1-4or 5+) U.S. ARMY COLONEL Baltimore, Maryland 18 Mother's Name (First Middle Meiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit thent of Health and Mental H lant; if them 27 is manked oth jury or other traumatic even Be ANTOINETTE HALL RIDGWAY P. SMITH, SR. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6238 RADCLIFF RD ALEXANDRIA, VIRGINIA 22307 19a. Informant's Name/Relationship (Type, Print) MARGARET H. SMITH - WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL CEMETERY 8/15/00 ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DEMAINE FUNERAL HOME 21. Signature of Funeral Service Licenses 520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** SEPTICEMIA /Medical Immediate Cause (Final one-da disease or condition resulting in death) Examine CARDIAC ARRHYTHMIA Physician/Medical Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, physician the buria signed by the at d be detached to 23b. Did tobacco usa contribute to the cause of death? P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Ninknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 2 PNO 1 Yes 2 No of Vital 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Shpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury af Work? After Division or Attending 5 Pending investigation 1 Tyes 2 No death. ** Hospital or Attending 24 hours after death **

** Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end litle of certifier 10 po completed cause of death (Near 23a) (Type, Print that will rille Road; Bourie-Many 1000-11 30. Name and address of person who complete

Registrar

31. Date filed (Month, Day, Year)

AUG 0 7 2000

2

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Data of Death 3. Tima of Death .1. Decedent's Nama (First, Middle, Last) **Physician** SWINT LONNIE 8:30 a.m. AUGUST 1 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Temple Hills 3400 27th Avenue # Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (fn yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Months 1 ☑ M 2 □ F Yrs. Nov. 28,1927 Georgia **Director** 252 40 2292 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23s or 25s-f show must be notified at Prince George's Temple HIlls 1 Yas 2 No Maryland Directo 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 20748 USA 3400 27th Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 ☐ Yas 2 ☐ No If Yas, Giva Yaer or Detes: 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 8 1 ☐ Yas 2 ☐ No Specify: Specify Black Ag 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Hygiene. Construction Worker Private 9th 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental int: If them 27 is menked of Lun Swint Margie Ingram 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) 10 3400 27th Avenue Temple Hills, MD 20748 Grace Ogunnaike/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20a Method of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Weportant: I any Injury o 4 ☐ Donation 5 ☐ Othar (Specify) Washington National Cem 8-5-00 Suitland, Maryland 22. Nama and Addrass of Facility MARSHALL S FUNERAL HOME OF MD Suitland, MD 4308 Suitland Road 234. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Betwaen Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Cancer 2/240005 - wedlinks Due to (or as a consequence of). Examine Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or Injury Dua to (or as a consequance of) Box 68760. Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown E of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an eutopsy The law 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medical axaminar? Cartification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Affine Division or Altending 1 SNaturat 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicide a Por Hospital 24 hours edical (15 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete end place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Within 2 To the To the 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signatura and title of certifiar derve un D35206 August 4, 2000 30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print) 11701 Livingston Ro, Fart WASHingson uns William T. TANNER M

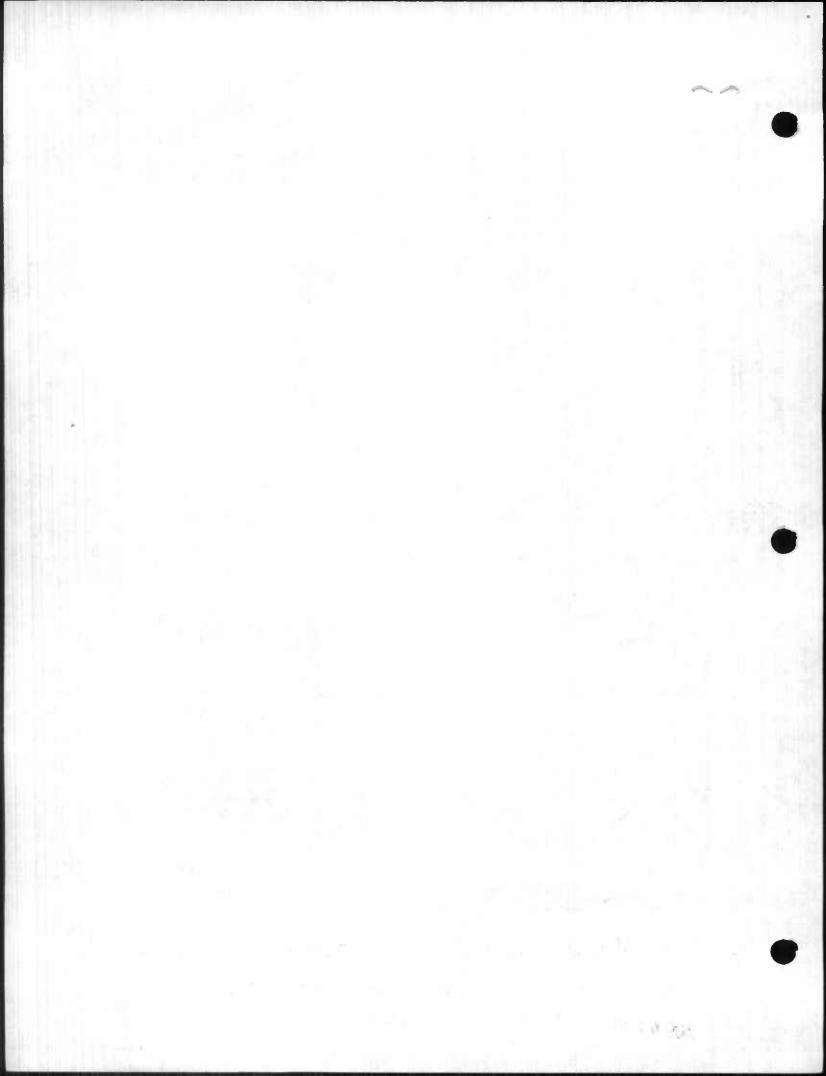
Registrar

State

31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

						Certificate of	Death		eg. No.	26822
П	Physic	ian	1. Decedent's Nama (First, Middle, Las	•				2. Dete of Dea		3. Time of Death
Ų.	/Medi		Evelyn	Scott				August	4, Dey 2000	8:25 PM
	Exami	ner	4a. Fecility Name (If not institution, give				4b. City, Town, or I	ocation of Death	4c. County o	
			Bradford Oaks Nur			WILL-I A V	Clinton			Georges
	Funeral Director		5. Social Security Number 6. Si 018-03-9077	ax 7. Age (In yrs 84		hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day Nov . 20	,1915 N	9. Birthplace (State or Foreign Country) New York
	land		10a. State 10b. County	10c. C	ity, Towr	or Location				10d. Inside City Limits
	Sa-f sho	Director	Maryland Prince	Georges Tem	ple	Hills				1 ☐ Yes 2 ☑ No
	23s or 2	rai Dire	10e. Street and Number 4311 23rd Parkwa	у		10f. Zip Code 20748		1	0g. Citizen of WI USA	net Country?
020	within 72 hours after death with the Meryland liena. 'than "netural", or items 23a or 28a-f show the Medical Examine: must be notified at	by Funeral	11. Maritei Status 1□ Never Married 2□ Married 3□ Widowed 4 ፟፟፟፟ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:	J,S.	13. Wes Decedent of I If Yes, specify Cub 1 ☐ Yes Ž☐ No		pecify Yes or No- pecify Yes or No- pecify Yes	Black	American Indian, White, etc.
2-0	72 ho	eted	15. Decedant's Ed (Specify only highest grad	ucetion de completed)	16a.	Decedant's Usual Occup (Give kind of work done life. DO NOT use retire	pation	kina	16b. Kind of Bus	iness/Industry
Maryland 21215-0020	within iena. Than	Completed	Eiamantary/Secondary (0-12)	Collage (1-4or 5+)		life. DO NOT use retire	ddring most or wor	1	Drug Enf Agency	forcement
b		Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	na (First, Middle, i	Maiden Sumame)
yla	should be ind Mental i marked o	To	Leonard Ethelbert	Scott			Annie	Evelyn	Ford	
Jar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (7)	ype, Print)	19b.	Mailing Addrass (Street	and Number or Ru	ral Route Number	City or Town, S	itata, Zip Code)
4	드등 전 느		Philip G. Hanson/B			.8 Foster Is				
0	80 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ I	Removel from State	Place of cemeter	Disposition (Name of v, crematory or other pla	ce)	Date	20c. Location - C	City or Town, State
E	men tant: jury		4 ☐ Donation 5 ☐ Other (Specify) Me	trop	olitan Crem	natory	8/5/2000	Alexand	Iria, VA
Baltimore,	Department Important: any Injury once.		21. Signature of Printral Service Country	also		22. Name end Addre George P. 6160 Oxon	Kalas Fu Hill Rd	neral Ho	me, P.A.	20745
	Physician		23a. Pert1. En	lications that caused the dee one causa on each line.	th. Do n					Approximate Interval Batween Onset and Death
	/Medical		Immediate Causa (Final disease or condition	a colon c	mac	0/				2
	Examiner		resulting in daath)			onsequance of):				2 40015
-	D #	iner								
	rificate be assecuted ng physician and es the burial-trensit	Medicai Examiner	Sequentially list conditions,	Dua to (or as a c	onsequance of):				
68/60,	be an ician buna	a E	Sequentially list conditions, if any, laading to immediate ceusa. Entar Underlying Cause (Disease or injury	c						
8	physis the	dic	that Initiated avants resulting in death) Last	Due to (d	or as a co	onsequence of):				
×		M		d						
POX	death death de etten	clar								
5.	thet the death ce ed by the ettendii detached for use	Physician/	Part II. Other significant conditions con	ntributing to death but not rea	sulting In	the underlying cause given	en in Part I.	23b. Dld to	bacco use conti	ribute to the cause of death?
	igned by be deta	by Pi						1 U Y	2 2 No 3	3 Probably 4 Unknown
Division of vital Records,	w requir	Completed b						24a. Was a perform	n autopsy ned?	24b. Were autopsy findings available prior to completion of ceuse of death?
r .	ilcian: The lav certificate has rector, page 2	Eo						1 🗆 Ye	s 2 No	1 ☐ Yes 2 ☐ No
0	an: rtifica	Be C	25. Was cese referred to medical				26. Place of Dea	th (Check only on		
>	Physician: The la r this certificate has eral director, page 2	ToE	examinar?	Hospital:	ER/Out	patient 3 DOA Oth	or	ome 5 Reside		(Specify)
ono	Attending Ph r death. ector: Affar th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Day Year)	28b. Ti	jury Wor		28d. Dascribe ho		
DIVIS	三元等の	Certification:	3 Suicide 6 Could not be datermined	28e. Place of injury - At h building, etc. (Specification)	ome, fen	m, street, factory, office		28f. Location (St City or Town		or Rural Route Number,
	To the Hospital ithin 24 hours a To the Funeral I	edicai (29a. Certifier (Check only one) Certifying Physical Exami	alcian: To the best of my kno iner: On the basis of examina and menner stated.	wledga, ition and	death occurred at the tir for investigation, in my o	na, date and place, plnion, death occur	and dua to the cared at the time, do	usa(s) and mannate and place, en	ner as stated. Indicate the decise of the de
	ithin To the		29b. Signeture end title of certifier			29c. Licens	e number	2	d. Dete signed	(Month, Day, Year)
1	2		I ditte	211000 1		100	701			
1	8)	-	30. Name and address of person who co	ampleted cause of death (item	n 22a\ /3	(D S)	COR		riag wit	>, car
1			1-11:	ANNER US	200) (1	Type, Print) 1701 Wing	che les 1	THE LANGE	with m	h
	Sta	te	31. Data filed (Month, Day, Year)		atura	,	1010	0.00 ani	11.01	-
	Registr		AUG 0 7 2000 &	32. Registrar's Signa	1	- 41				

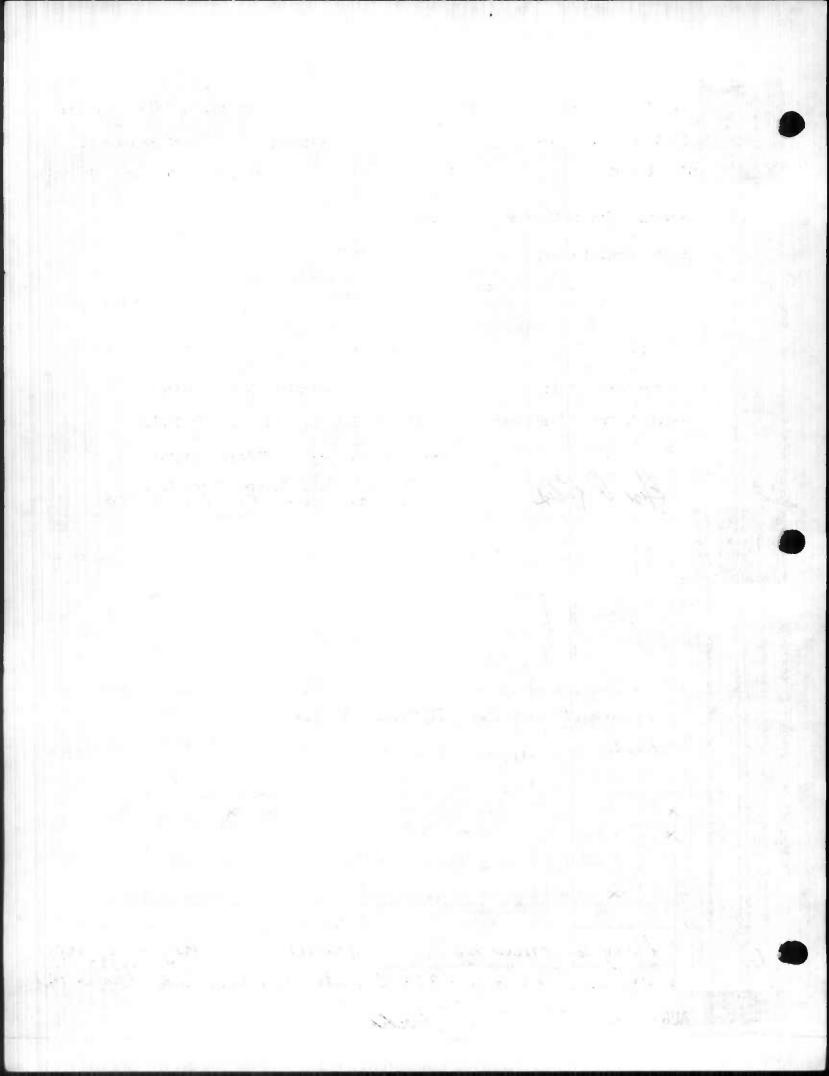
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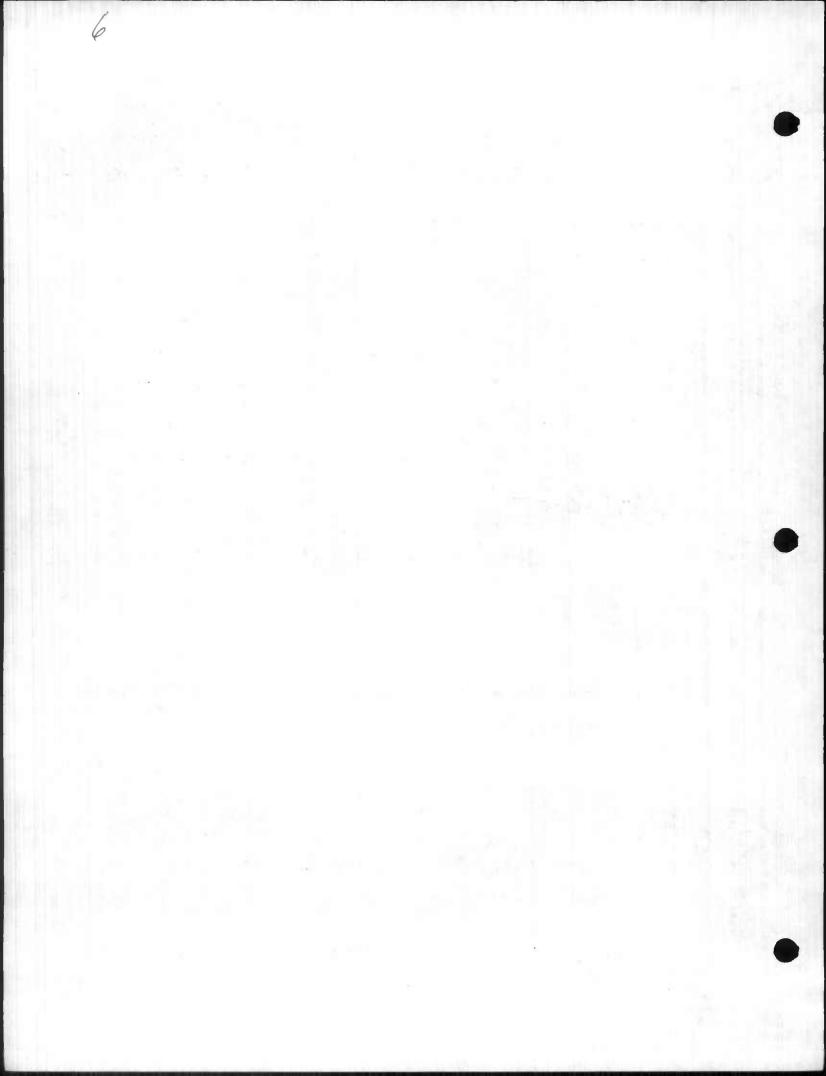
				Cen	ilicale	9 01 1	Death			Reg. No.			0020
an	1. Decadant's Name (First, Middle, L.	ast)							2. Date of D Month	eath Day	,	Year 3	. Time of Death
an al	Goldie Mae	Shav	er						August		2000		2:30PM
er	4a. Fecility Name (If not institution, g.	ive street end number)				4	b. City, To		cation of Dee	-		of Death	2.30111
	3004 Fairhill Co	ourt					Suit!	and		Pr	ince	Georg	100
			(In yrs. last bir		If Under	1 Yeer	If Under	24 Hrs.	8. Date of B	rth	1		
	070-01-8595	1□ M 21 F	104	Yrs.	Months	Days	Hours	Min.	(Month, D	ey, <i>Year)</i>	5	West V	irginia
	Usual Residence of Decedent						1	1 44	45. 22	,100		WC3C 1	riginia
	10a. State 10b. County		10c. City, Town	n or Loca	ation							10d.	Inside City Limit
to	Maryland Prince	Georges	Suitl	and									1 Yes 2 N
Je C	10e. Street and Number				10f. Zip (Code				10g. Citi	zen of W	Vhat Country's	
Funeral Director	3004 Fairhill Co	urt				0746				USA			
era	11. Maritel Status	12. Was Decedent E	ver in U.S.	13 W				igin? (Sne	olfy Vee or N		14 Bace	e - Americen I	ndien
Fu	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2000		11	Yes, speci	fy Cube	n, Mexica	n, Puerto F	olfy Yes or N Ricen, atc.)			k, White, etc.	1101011,
by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		10	Yes 2	KNo	Specify	:			Specify.	White	
8	15. Decedent's E		160	Decede	nt's Usuai	Occur	etlon						
Completed	(Specify only highest gi	rede completed)	100.	(Give ki	ind of work	done o	during mos	st of workin	9	160, KI	110 01 60	isiness/Indust	ıy
E	Elamentary/Secondary (0-12)	College (1-4or 5	+)		makei		,			At 1	Home		
	17. Father's Name (First, Middle, Las	#)			marco		10 Math	orla Nama	(First, Middle				
Be												е)	
2	George Milton Ha						Harr		Myra	Roge			
	19a. Informant's Name/Relationship											Stata, Zip Co	de)
	Evelyn T. Cristy/	Daughter					Ct.,	Suit	land,	MD 20	0746		
	20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 [TRamaval from State	20b. Piace of cemeter	Disposit ry, crema	tion (Nematory or off	e of her plea	e)	1	Date	20c. Lo	cation -	City or Town,	State
	4 Donation 5 Other (Special		Cedar	Hil.	1 Cen	nete	ry	8/8	/2000	Suit:	land	, MD	
	21. Signatury of Funeral Service Line	9100		22.1	Name end	Addres	ss of Fecili	ity_					
	Den H. Ku	4		Geo	rge l	. K	alas	Fune	ral Ho	me,	P.A.		
\rightarrow	23a. Patri. Enter the disease, or con								Oxon H		MD		proximate
/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last	c	Oue to (or as a c										
ian/Me		d											
Physician	Part II. Other significant conditions	contributing to death bu	t not resulting In	the und	lerlying ca	use give	en in Part	1.	23b. Dld	tobacco	use con	tribute to the	cause of death
	Dement	in Ca	20 1 4	T		7/0	2-1	+	10	Yes 2	No	3 Probabl	y 4 Unknow
þ			1		~	, , ,	100						
Completed	Dem ent Failure	71	tour	1						an autop ormed?	sy	evallat	utopsy findings le prior to
ğ		Type	LEVEL	A-P-Y	•							of deat	efion of cause h?
5									10	Yes 2	No	1□Ye	s 2 No
23							26. Place	of Deeth	(Check only	one)	•		
	25. Was cese referred to medical	Hospital:	f 2 ER/Out	tpetient	3 DOA	Othe	ar:		e 5 Res		Othe	r (Specify)	
o Be	25. Was cese referred to medical examiner? 1 Yes 2 No	1 L Inpatier			28	-			3d. Describe				
To Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. T	HITO OI		Work	(7)						
To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. I	njury	м		Yes 2	No					
To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) Ir	njury		101			3f. Location (Street end	d Numbe	er or Rural Ro	ute Number.
To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	Year) Ir	njury		101			31. Location (City or To			er or Rural Ro	ute Number,
Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined	28a. Date of Injury (Month, Day) 28e. Place of Injury bullding, etc.	Year) Ir ry - At home, far (Specify)	njury rm, strea	if, factory.	1 🗆 Y	Yes 2□	21	City or To	wn, State)			
Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined 4 Homicida 29a. Certifier 1 Certifying Pt	28a. Date of Injury (Month, Day	ry - At home, far (Specify) my knowledge,	njury rm, strea	if, factory,	office	Yes 2□	29 and place, an	City or To	wn, State)	and mar	nnar es stater	1
edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined 29a. Certifier (Check only) 2 Medical Examiner	28a. Date of Injung (Month, Day on Day 28e. Place of Injung building, etc. on yellotan: To the best of on the basis of the second of the secon	ry - At home, far (Specify) my knowledge,	njury rm, strea	occurred at	office	Yes 2□	29 and place, an	City or To	wn, State) causa(s) data and	and mar place, a	nnar as stated	l. cause(s)
edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined 29a. Certifier (Check only one) 1 Certifying Proceedings of the could not be datermined.	28a. Date of Injung (Month, Day) 28e. Place of Injung building, etc. 28e. Place of Injung building, etc. 28e. Place of Injung building, etc.	ry - At home, far (Specify) my knowledge, axamination and	njury rm, strea , daath o	of, factory, occurred at stigation, in	office the timen my op	re, data an binion, dea	20 d place, ar	City or To	causa(s) data and 29d. Date	and mar place, a	nnar as stated and due to the	i. cause(s) Year)
Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injung (Month, Day) 28e. Place of Injung building, etc. 28e. Place of Injung building, etc. 28e. Place of Injung building, etc.	ry - At home, far (Specify) my knowledge, axamination and	njury rm, strea , daath o	of, factory, occurred at stigation, in	office the timen my op	re, data an binion, dea	20 d place, ar	City or To	causa(s) data and 29d. Date	and mar place, a	nnar as stated and due to the	i. cause(s) Year)
Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined 29a. Certifier (Check only one) 1 Certifying Proceedings of the could not be datermined.	28a. Date of Injung (Month, Day) 28e. Place of Injung building, etc. 28e. Place of Injung building, etc. 28e. Place of Injung building, etc.	ry - At home, far (Specify) my knowledge, axamination and	njury rm, strea , daath o	of, factory, occurred at stigation, in	office the timen my op	re, data an binion, dea	20 d place, ar	City or To	causa(s) data and 29d. Date	and mar place, a	nnar as stated and due to the	l. cause(s)

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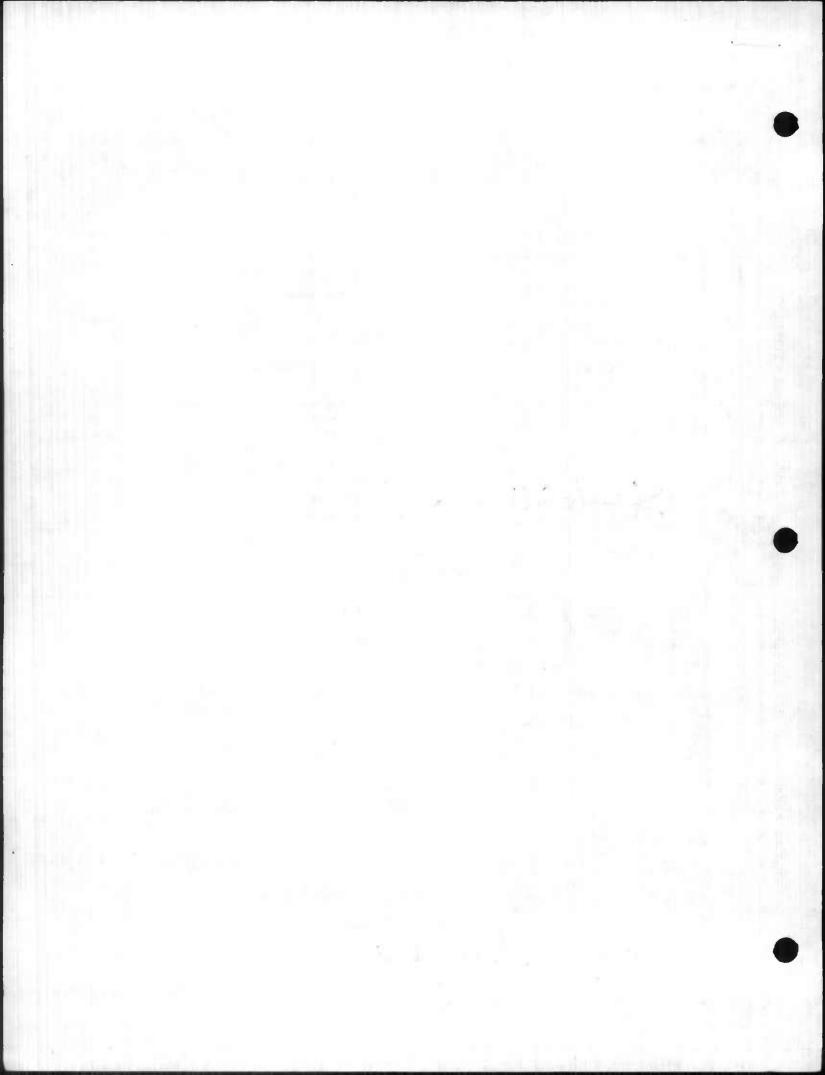


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** ALGUST MICHELE ANNETTE SORRELLS 0054 2000 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clin ton Hospital Prince Southern Maniford Gernes If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) FEB 7, 1971 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2□F Hours 215-13-2659 Washington, DC Director Usual Residence of Decedent the Maryland 10d. tnside City Limits 10a State 10h County 10c. City, Town or Location ahow "natural", or items 23s or 28s-f ahor He Yes 2□No Director Maryland Charles Waldorf 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 U.S.A. 2300 Ashford Lane Funeral death Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 27 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: p White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Mananger The marked other 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Christine Hayes Bragg Kenneth E. Bragg Sr 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traun 2300 Ashford Lane Waldorf, MD 20603 David Lee Sorrells (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ot Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 8-14-00 Waldorf, MD 21 Signature of Juneral Service Licensee 22. Name and Address of Facility Eberwein Funeral Service M00173 4433 White Plains Lane White Plains, MD 20695 The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and tailure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Self-inflicted Cowshot Wound to Head /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 93 USe signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records. g 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 20 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA 12 Yes 2 No Certification: To this 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred Self-inflicted garden shet wound to head 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural August 10, 200 23491 1 Yes 2₽No death. investigation 2 Accident 24 hours after deal Funeral Director: 28t. Location (Street and Number or Rural Royte Number, City or Town, State) 2228 Old Wishway faw ROAL Washington And Washington 2002 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) \$ 29b. Signature and titla of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Drive Chevely Hung knd 20785 3001 Hospital 31. Date filed (Month, Day, Year) 32. Registra/s Signature State AUG 15 2000 Deperon Registrar

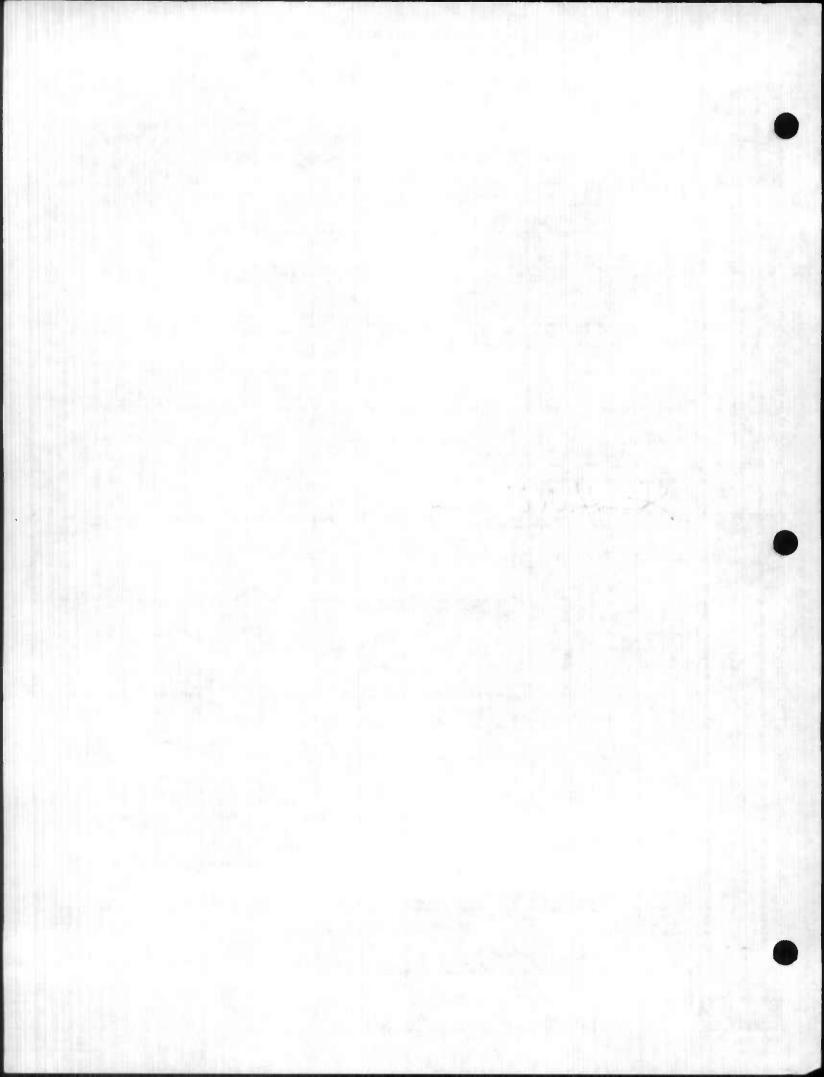


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n r	Rose sa A. S								Month	Day 200	Year	125pm	
al	citity Nama (If no			number)		#20		4b. City, Town, or			y of Death	12001	11
	909 Peni				5 Penr	field	Circle	Silver S	pring		gomer	У	
22	ial Security Num	22	8. Sex 1 ☐ M 2 🔀 F		In yrs. last b		H Under 1 Year Months Days		8. Data of Bir (Month, Di May 3,	ay, Year)	9. Birthi Coul MD	place (State or ntry)	Foreign
Usual	Residence of De	ocedent Ob. County		1	Oc. City, Toy	vn or Loc	ation					IOd. Inside City	v Limits
MD		Montg	omeru		Silve							1 ☐ Yas	
	Street and Number			5101		1	10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	909 Ponr				CIICIE	#40	20906			United			
11. M	arital Status Nevar Married Widowed 4	2 Marrie	12. Was Do Armed 1 Tyes, If Yas,	ecedent Ever Forcas? is 2 No Giva	er in U,S.	H.	/as Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (S van, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Ble	ice - Americ ack, Whita,		
31		. Decedent		r Dates:	16	Dacada	ent's Usual Occu	netion		16b. Kind of I		duetes	
Ele	(Specify mentary/Seconds 12	only highest	grade complete	ed) e (1-4or 5+)	_	(Give k lifa. D	ind of work done O NOT use retire unch Ope	during most of world)	king	Govern		oustry	
17. Fa	ther's Name (Fir	st, Middle, L	ast)					18. Mother's Nar	na (First, Middle	, Maiden Suma	ma)		
Sa	muel C	aplan						Sara Z	ipper				
	Informant's Name							t and Number or Ru					
-	than Sch		r /Husb	and			Pennfie	eld Ct #	2D, Sil				06
1	Aethod of Dispos ☐ Burial 2 🖹 € ☐ Donation 5 [remation		m Stata	cemate	ery, cremi	ition (Nama of atory or other pla ke Crema	1	Aug 10 2000	20c. Location Beltsv			
21.5	ignature of Funar	al Service L	icensee			22. F	Nama and Addra Rapp Fun 933 Gist	eral & Ci Avenue	remation Silver				
Imme	shock, or heart le diete Causa (Fin sa or condition	oilura. List c	nly ona cause or	n each line.			cthe mode of dyi	ing, such as cardiae	c or respiratory a	mest,	1	Approximata Interval Betwonset and D	veen Seath
rasun	ing in death)			Du	e to (or as a	consequ	ience of):				1		
Sequi if any cause Cause	entially list condit , leading to imme o. Enter Underlyi e (Disease or inju	lons, idiate ng	6	Du	a lo (or as a	consequ	ence of):	5			1		
majir	itiated events ' ing in death) Las		d	Du	e lo (or as a	conseque	ence of):						
Part II	Other significa	nt condition	e contribution to	death but	not moulting	in the unv	darbrina cauca ni	von in Part I	23h Did	tobacco use c	ontribute t	o the cause of	d cleath'
			so continuously to	, douth but t	ior resummy	in the tirk	oonyang causa gi	VOIT NI P QUIT.		Yes 2☐No		bably 4 1	
		125					Year.			an autopsy ormed?	84	fare autopsy tii railable prior to empletion of ca death?	
									10	Yes 2 No	1	□ Yes 2 1	No
0)	as casa refarred	lo medical						26. Place of Dea	ath (Check only	one)			
27. Mc	Accident	Pending investigation of the determine	28a. Da (Mi	Inpatient ta of Injury onth, Day Y	- At homa, I	Tima of Injury	28c. Inju	ny et ork?] Yas 2 ⊠No	28f. Location	idence 6 O how injury occu (Street and Num wn, Stata)	irred		ber,
29a. (Check only 2		Physician: To t	he best of r	ny knowledg			ima, data and place)
-	one)		and mi	annar state	d.								
290. 5	ignature and title	D	61	1.	1	1	29c, Licens			29d. Data sign	- (Monin,	O O O	
16	lun	lyn	V H	Em	dru	ho	MD3723	36		augus	uo	7,200	0
	ma and address arolyn H		no completed ca lricks M					#300, Bet	hesda.	MD 2081	7		
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State of Maryland / Department of Health and Mental Hygiene

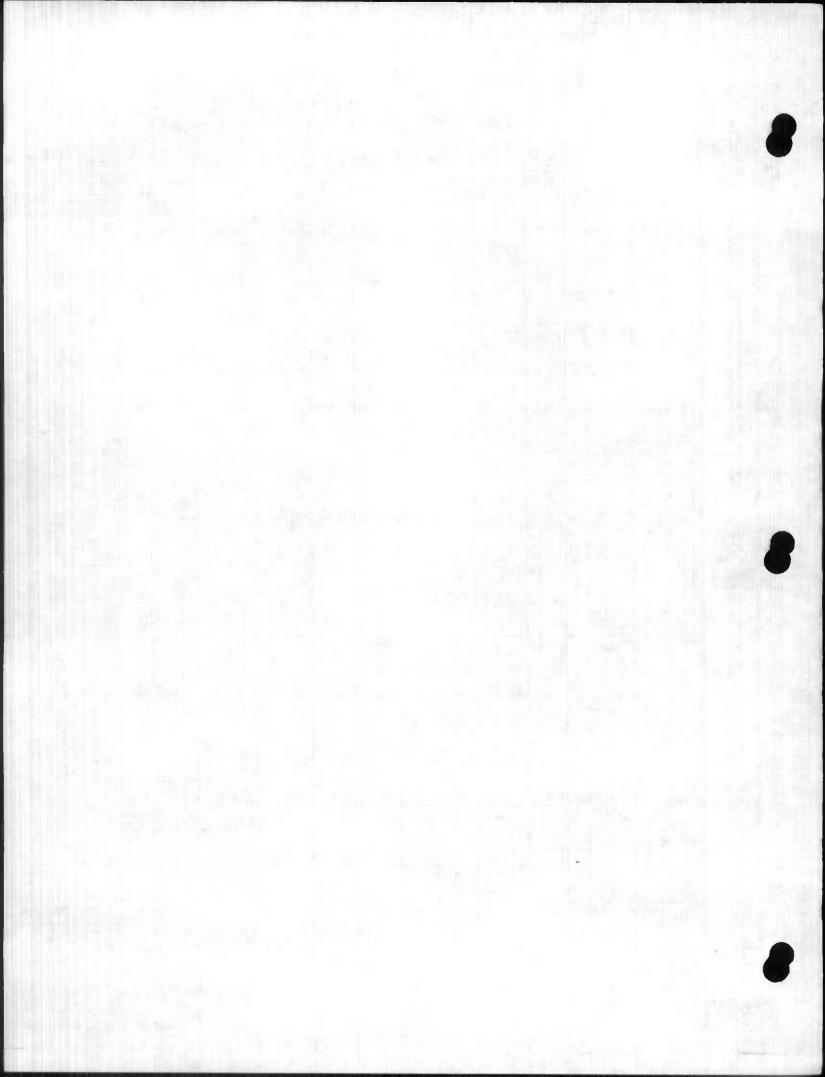
			(Certificat	e of Deat	h	R	eg. No.	10	268	26
Dhuaisian	1. Decedent's Neme (First, Middle, La	st)				2.	Date of Deat Month	Day	Year	3. Tima of	Death
Physician /Medical	Donna Sue Scheik)				1	August		0	1015	am
Examiner	4a Facility Name (If not institution, giv 11729 College Vi					Town, or Locati aton	ion of Deeth	4c. County Mont	of Death gomer	У	
uneral irector	5. Sociel Security Number 6. S 072-38-1407	Sex 7. Age	(In yrs. last birth 53 y		1 Yeer If Und Days Hour	er 24 Hrs. 8. s Min.	Dete of Birth (Month, Day, Aug 22	, 1946	9. Birthpl Count NY	lece (State or try)	r Forei
	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location					1/	Od. Inside Cit	h, Limi
offiled at ector	MD Montgo		Wheat							1 Tes	
terns 23e or 25e-1 sho iner must be notified at Funeral Director	10e. Street and Number 11729 College Vi	ew Dr.		10f. Zip	Code 902		1		of What Country? ed States		
ar, or tame. Examiner ma	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ex Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		13. Wes Deced If Yes, spec	dent of Hispenic cify Cuban, Mexi 2 No Spec		Yes or No- an, etc.)		e - America ck, White, e		
wer than "natural, it its Medical. Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			life. DO NOT u	rk done during m			16b. Kind of Bu Privat			
	17. Father's Neme (First, Middle, Last)			18. Mc	ther's Name (F	irst, Middle, I	Maiden Suman	10)		
e e e e	Martin Schultz						11ack				
P P	19e. Intorment's Name/Reletionship (Type Print)	19h	Mailing Address	(Street and Nur			City or Town	State Zin	Code)	
11	Ken Nicholls /Pe	*			more Rd					_	
if Item 2 or other	20e. Method of Disposition 1 Durial 2 Cremetion 3 D	Removel trom State	20b. Plece of I cemetery	Disposition (Nar crematory or o	ne of other place)	A	oete 1g 9	20c. Location - Beltsv	City or To	wn, Stete	
dury (uny	4 Donetion 5 Other (Special		Chesa		remator		000			110	
any ir ance	21. Sign turn Funerel Service Licar	0, 0		d Address of Fa Funeral Gist Ave	& Cremenue Si	nation Llver	Servic Spring,	es MD			
esician	23a Part Elter the disease, or com shock, or heart feilure. List only	plicetions that caused to one ceuse on each line	he deeth. Do no	t enter the mod	le of dying, such	es cardiac or re	espiratory err	est,		Approximeta Interval Bety Onset and D	meen
edical aminer	tmmediate Ceuse (Finel disease or condition Metastatic acinic cell carcinoma										ar
ě	resulting In deeth)	D	ue to (or as a co	onsequence ot):					1		
physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or es a consequence of): c. Due to (or es a consequence of):										
0 11	Cause (Diseese or injury thet initieted events resulting in death) Last	c	ue to (or es a co	nsequence of):					-		
attending for use a		V.									
by the lached	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying o	cause given in Pe	ert I.		ss 2 No		the causs of the causs of the causs of the causs of the causs of the causs of the cause of the c	
been signer should be d							24e. Wes e		ave	ere eutopsy fi allable prior to appletion of co	0
Has Per							1 🗆 Y	es 2 No		death? ∃Yes 2☐	No
# o	25. Was case referred to medical				26. PI	ece of Death (C	Check only or	ne)	1		
00	examiner? 1 ☐ Yes 2 ☐No	Hospitel:	2 ER/Out	patient 3 DC	100	Nursing Home			er (Specifi	y)	
5 7	27. Menner of Death 1 Death 5 Pending	28a. Dete of Injury (Month, Day	28b. Ti		28c. Injury at Work? 1 ☐ Yes 2	280		ow injury occur			
of the	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Diana et laive	y - At home, ferr (Specify)				Location (S City or Tow		umber or Rurel Route Number,		ber,
	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner (Check only one) 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner of manner of the cause(s) and manner of manner of the cause(s) and manner of manner of the cause(s) and manner										:)
e Fum letely	one)			290	c. License numb	er	2	9d. Date signe	d (Month,	Day, Year)	
ompletely fill	29b. Signature end title of certifier										
Completely filled in b	29b. Signature end title of certifier **Delta*	f. Shape			35336		1	lugust	08,	2000)
C To the Fund completely d	29b. Signature end title of certifier	completed cause of dec	oth (Item 23e) (T	ype, Print)				Jugust	08,	2000)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 2 5 9 2 7

	Certificate of	of Death	Re	g. No.	20021
Physician	1. Decedent's Neme (First, Middle, Last) MARS (NI SEI	NGER	2. Date of Death Month August	Day Year	3. Time of Death 11:58 pm
/Medical Examiner	4e Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		4c. County of De	
	Suburban Hospital	Bethe			tgomery
Funeral Director	5. Social Security Number 579-66-1674 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) Fig. Months Da Wonths Da Wonths	eer If Under 24 Hrs. ays Hours Min.	8. Dete of Birth (Month, Day, December		inthplace (State or Forei Country) Argentina
Du Bu	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Lim
Many fled	Maryland Montgomery	Bethesda			1 □ Yes 2 💢
or 28s-1 s be notified Director	10e. Street and Number 10f. Zip Cox		10	0g. Citizen of Whet 0	Country?
	4970 Battery Lane #303	20814		United	States
r here 23 ioer must Funeral	11. Meritel Stetus 12. Wes Decedent Ever in U,S. 13. Wes Decedent If Yes, specify (If Yes) (If Yes, specify (If Yes)	of Hispenic Origin? (Spe Cuban, Mexicen, Puerto	cify Yes or No- Rican, etc.)	14. Rece - An Black, Wh	nerican Indian, nite, etc.
fr. or h	1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give 1 Yes 2	No Specify:	ntine	Specify:	White
	15. Decedent's Education 16a. Decedent's Usuel Oc	ccupation		16b. Kind of Busines	
ygiene. se then "ratur t, the Medical.	(Specify only highest grade completed) (Give kind of work of life. DO NOT use re	one during most of works stired)	ng		
Con the		rber			Employed
Be well	17. Father's Neme (First, Middle, Last)	18. Mother's Nema	(First, Middle, N	Maidan Sumeme)	
Man Man	Pedro Senger			t Tailoff	
d a man	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (St.				
m 27	Graciela Senger/ Wife 4970 Battery 20e. Method of Disposition 20b. Plece of Disposition (Name Lane #303		la, Maryla		
0 m 0	1 X Burial 2 □ Cremetion 3 □ Removel from State	plece)	ugust		
than than the same of the same	4 □ Donation 5 □ Other (Specify) Gate of Heaven	Cemetery 4	, 2000 S	ilver Spr	ing,Maryla
Depar Impor	21. Signature of Funerel Service Licensee Robert A. Bethesda- Bethesda- Bethesda-	dress of Fecility Pumphrey -Chevy Chas Maryland	Funeral	Home/ 7557 Wisc	onsin Aven
0.00	23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dylng, such es cerdiec d	r respiratory erre	est,	Approximata Interval Between
hysician					Onsat end Death
/Medical Examiner	Immediate Causa (Final disease or condition	FAILURE			
	resulting in death) Dua to (or as a consequence of):				
n and heldransit	D.				
be executed total and buniel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying BRONCH (ECTAS)	<			1
physician is the buria	Cause (Disease or Injury that initiated events)			
ng phys as the	resulting in death) Last				
requires that the open certificate be expensed by the attending physician should be detached for use as the burial though by Physician/Medical E.	d.				1
y the school	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause	e given in Pert I.			Probably 4 20 nkg
gned by deta	MALNUIKITION, EXPHAGEAL C	ANCER	1 U Y	ee 2□No 3□	Probably 4 Onkr
D 42 07			24a. Wes e perform		b. Ware autopsy findin eveilable prior to completion of cause of death?
ate has b page 2 s			1 □ Yε	a 2 2No	1 ☐ Yes 2 ☐ No
certificate has rector, page 2	25. Was case rafarred to medical	26. Place of Deat			
r this certificated and director.	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA	Other:		ence 6 Other (S	pecify)
2 2 2	27. Mannar of Death 28a. Data of Injury 28b. Time of 28c.			ow injury occurred	
Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Attending Professional Professional Attending	2 Accident Investigation M	1 ☐ Yes 2 ☐ No			
after death Director: J in by the	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	fice	28f. Location (St City or Town	treet end Number or n, State)	Rural Route Number,
4 hours Funeral tely filled	29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, death occurred at the control of the contr				
within 2 To the comple		cense number	2	9d. Date signed (Mo	onth, Dey, Year)
~ /x	1 1 1	026571		8/2/0	0
10 10	30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)	0011		01 10	1 1:0
	IRVING MIZUS, MD 4930 DEL	RAYAV	E B	FIHESE	14, MD 20
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture				

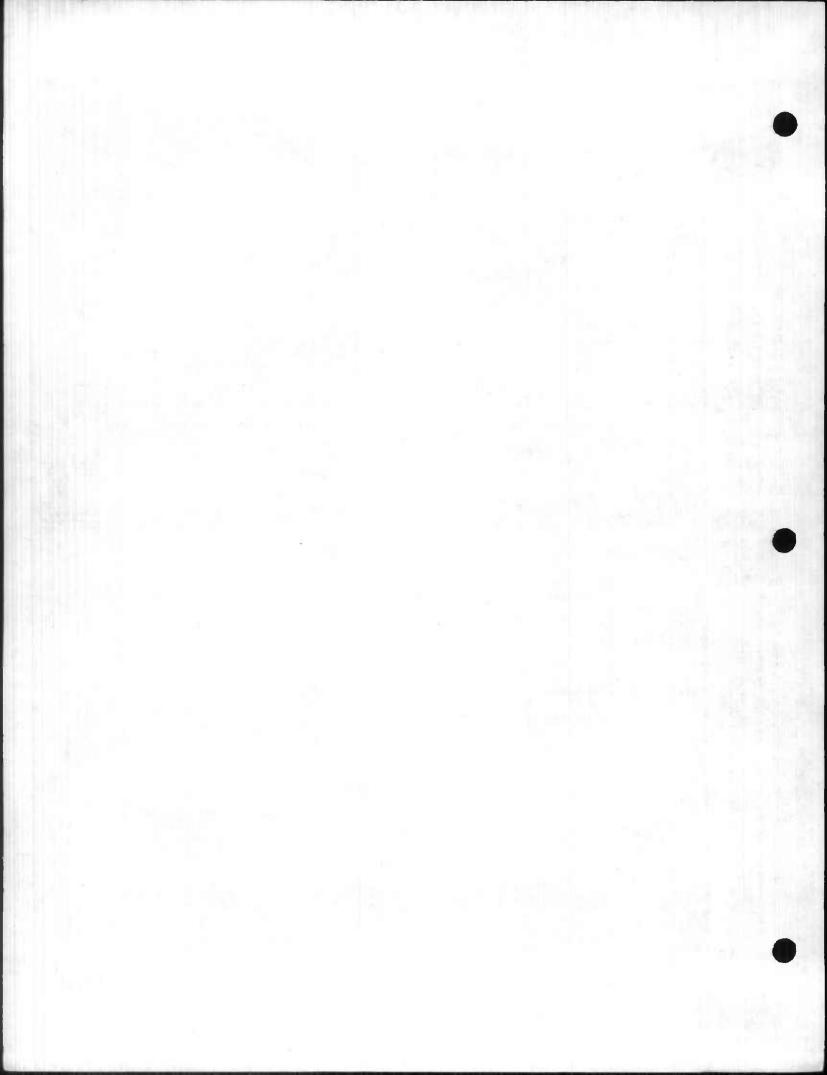
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State of Maryland / Department of Health and Mental Hygiene

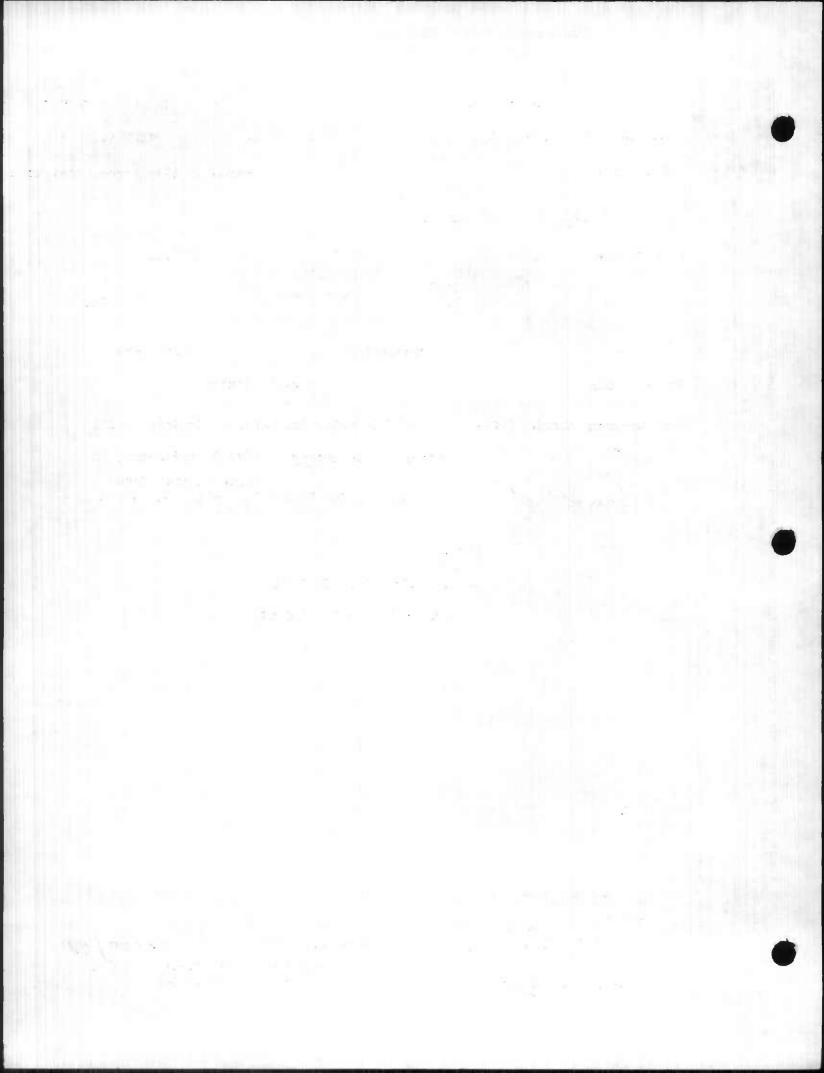
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			Certificate	of Death	F	eg. No.	200	40
1	1. Decedent's Name (First, Middle, Le	ist)	The Hall bear	U STORY	2. Data of Dea Month	th Dev	3. Tima	of Death
Physician /Medical	Katheri	ne E. Spac	dacini		August		7:20) AM
Examiner	4e Facility Neme (If not institution, gi			4b. City, Town, o	or Location of Death	4c. County	of Death	
	Dilrani Elder Ca	re		Barnesv:	ille	Montg	gomery	
Funeral		Sex 7. Age (In yrs. la:	st birthday) If Under 1	Year If Under 24 H Days Hours M		Year)	9. Birthplace (Stere	or Foreign
Director	577-20-7607	1□M 2\XF 80	Yrs.	-5,-	Aug. 13	, 1919	West Virg	inia
ms 23s or 28s-f show Limitation notified at	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location				10d. Inside	City Limits
ahow dat							100.000	s 2 XNo
be notified at Director	Maryland Montgom	ery Ger	rmantown			0.00		
0 %	10e. Street and Number		10f. Zip C			Og. Citizen of V		
e 23a	17412 Siever Cour	~		20874	(Specify Vec or No		States - American Indien,	
ther must	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	If Yes, specif	nt of Hispanic Origin? ly Cuban, Mexican, Pu	erto Rican, etc.)	Blac	k, White, etc.	
ical Fram	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 🗆 Yes 2	No Specify:		Specify	White	
	15. Decedent's E		16a. Decedent's Usual	Occupation		16b, Kind of Bu		
rt, the Medical	(Specify only highest gr	ade completed)	(Give kind of work life, DO NOT use	done during most of v	vorking	TOD, TUNG OF DO	an local in locality	
d die	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemak	er		Hor	ne	
1 .	17. Father's Name (First, Middle, Last)	1101110111011		lame (First, Middle,			
To Be	John	Fortini			Maria		Moretti	
6	19a. Informent's Neme/Relationship		19b. Mailing Address (Street and Number or		r, City or Town,		
T.	John Spadacini/Hu	ishand	17412 Sieve	ar Court C	Cermantown	. Marvl	and 20874	
any injury or other traumatic avenue	20a. Method of Disposition	20b. Pta	ce of Disposition (Name	e of	Dete		City or Town, State	
7 04	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci	JHemovel from State	netery, cremetory or other ary Cemete		8/8/00	Thomas	Most Win	ed m d e
Injur	21. Signature of Funeral Service Lice		-	Address of Fecility	1		West Vir	ginia
any l	D11. 0	Och U. V. S.		eer Park Di				1877
	23a. Part1. Enter the disease, or com	religations that assumed the death					Approxim	
	shock, or heart failure. List only	one cause on each line.	DO NOT GIVEN THE WHOLE	or dying, soon as card	ac or respiretory an	431,	Interval B	letween
cian lical	Immediate Cause (Finel	CARRIADA	MARY A	0020				
niner	disease or condition resulting in deeth)	a. CARDIOPULMS Due to (or a	77	NIGC31			SMI	Nutes
ē								
m m		b. CORONARY	ARTERY D	USEASE			5 76	EARS
the burial-transit	if any, leeding to immediate						1000	
edical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. HYPERTENS	s a consequence of):				15 YE	ARS
2	resulting in death) Last	Due to (or a	s a consequence or.					
No.		d						
od fo	Part II. Other significant conditions of	contributing to death but not resulti	ing in the underlying car	use given in Pert I.	23b. Did to	obacco usa cor	itribute to the caus	e of death?
tach hy	ALZITEIMER				101	08 2 XNO	3 Probably 4	Unknown
o de	ALLITEINER	s pisenje			_			
cate has been signed by the attendin . page 2 should be detached for use . Completed by Physiciar/N					24a. Was a	n autopsy	24b. Were autops available prid	y findings or to
2 she					-	illou i	completion of death?	f cause
director, page 2 s					1 D Y	es 25No	1 ☐ Yas 2	□ No.
9 0	25. Was case referred to medical			26 Place of F	Death (Check only or		10.00	3.10
I director, page To Be Com	examiner? 1 Yas 2 No	Hospitel: 1 Inpatient 2 El	R/Outpatient 3 DO/		Home 5 Resid		(Specify) E 1 d	on Cono
	27. Manner of Death		8b. Time of 28	c. Injury et Work?	28d. Describe h			ip Home
to tun	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 Yes 2 No			0202	.p mome
1 th	3 Suicide 6 Could not b	Zoe. Flace of injury - At nom	e, ferm, atreet, fectory,	office	281. Location (S	treet and Numb	er or Rural Route N	ımber,
completely filled in by the funeral Medical Certification: 1	4 Homicide	building, etc. (Specify)			City or Tow	n, State)		
al C	29a. Certifier 1 (X) Certifying Pt	ysician: To the best of my knowle	edge, death occurred at	t the time, date and pla	ice, and due to the d	ause(s) and me	nner es stated.	
pletely fill	(Check only 2 Medical Example)	niner: On the basis of examination and manner stated.	n and/or investigation, i	n my opinion, death oc	curred at the time, o	late and place, i	and due to the cause)(s)
E S	290. Signature and title of certifier	10	29c.	License number	1	9d. Date signer	(Month, Day, Year)
	1/1/t	Great M.	2	007162		August	3, 2000	
10	30. Neme and address of parson who	completed cause of death floor	(3a) (Type Print)			nugust	J, 2000	
	Martin Graf, M.D.			Suite #20	3 Rocky	11e MT	20850-3	3234
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Signatur	00 4		JO ROCKV.	TIC9 KILL	20000	, L J T
State Registrar	Align 7 20	6	B. Spor	Kes				



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			Cel	niiicai	e or	Death		Re	g. No.			
Physician /Medical	Decedent's Nama (First, Middla, L. C.	ALHOUN SMITH						ata of Death Ionth AUG	Day	Yaar)	3. Tima of 3:33	
Examiner	4a Facility Name (If not institution, gir NATIONAL NAVAL M					4b. City, Too BETH	wn, or Location	n of Death	4c. County MON	of Death	ERY	
Funeral Director	5. Social Sacurity Number 6. 577-28-2163 Usual Rasidance of Dacadant	Sax 7. Aga (In yrs		If Unda Months	r 1 Yaar Days	If Undar	Min. (A	ata of Birth Month, Day, ch 15	Year) ,1915	9. Birthp Cour Ancon	olaca (Stata o ntry) 1, Canal	Foreign
death with the Maryland ms 23e or 28a-1 show Linual be notified at	10a. Stata 10b. County	10c. C	ity, Town or Lo								0d. Insida Cli 1 ☐ Yas	
after death with the Marylar or items 23e or 28=f show more must be notified at Funeral Director	10e. Street and Number 4060 Ridgeview C	t. 12. Was Decedent Evar in I	IS 13 V	101. Zij	101	Hispanic Orig	nin? (Specify)	U	S.A.	What Cour		
ors after	1 Navar Marriad 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 Yas 2 No 19: If Yas, Giva Yaar or Datas: 19:	37	lf Yas, spe			gin? (Specify) , Puarto Ricar	atc.)	Specif	ck, Whita, y: Whi		
c - = =	15. Decadant's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ada complated) College (1~4or 5+)	16e. Deced (Giva life. I	kind of wo	ork dona sa retire	during most	of working		Compute		dustry	
pes 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic event, the Mean other traumatic events are supplied to the Mean of	12 17. Father's Nama (First, Middla, Last Frank Smith	0	TIOCE	SSTII	5	18. Motha	r's Nama <i>(Fir</i> s	st, Middla, N				
permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other fr	Ruth Goodman Smi 20a. Mathod of Disposition 1 Burial A Cramation 3 A Donation 5 Other (Special Signature of Funeral Service Lice	Ramoval from Stata	4060 Place of Dispo camatary, crar rthern	VA C1	ema	tory ass of Facilit	8/9/ Pearso	00 A	rlingto	on, V	'A	
Physician /Medical Examiner	472 N. Washington St. Falls Church, V 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): MULTI SYSTEM ORGAN FAILURE									1, V.A	Approximete Interval Beh Onset and I	e ween
certificate be executed ding physician and use as the burial-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last	METAS	Dua to (or as a consequence of): METASTATIC PANCREATIC CANCER Dua to (or as a consequence of):									
daath e atter ed for	Part II. Other eigniffcant conditions	contributing to death but not re	sulting In tha u	ndarlying	cause g	iven in Pert I		23b. Did tobacco uea contribute to the cause o				of death
requiras th								1 □ Ye 24e. Wes ar perform		24b. W	ere eutopsy frailabla prior tomplation of cideeth?	findings
ician: The law certificate has rector, page 2:								1 □ Ya	s 2 CXNo	11	□Yas 2□	No
uth.: Atter this certific e funeral director.	25. Was casa refarred to medical axaminar? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Panding 2 Accident Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of 28c. Injury at 28d. Desc			n (Check only ona) ma 5 Rasidanca 6 Othar (Specify) 28d. Describe how Injury occurred						
To the Hospital or Attanding Physisithin 24 hours after death. To the Funeral Director: After this completally filled in by the funeral directors and the funeral directors.	3 Suicida 6 Could not l 4 Homicida datamined	28f. L	ocation (St. City or Town	reet and Num n, Stata)	ber or Run	a <i>l R</i> outa Num	ber,					
thin 24 hour thin 24 hour the Funer mpletaly fil	29a. Certifiar Certifying Place (Check only one)						.)					
Within M	29b. Signature and the of certifier	Cares MD.				se number 1627 (CA)	25	9d. Data signe	od (Month,	Day, Year)	
	30. Neme and eddress of person who R.C.JONES, CDR,	MC, USN		Print)			NAL NAV			CENT	ER	
State	31. Data filed (Month, Day, Yaar)	32. Registrar's Sign	latura	1	- 4							

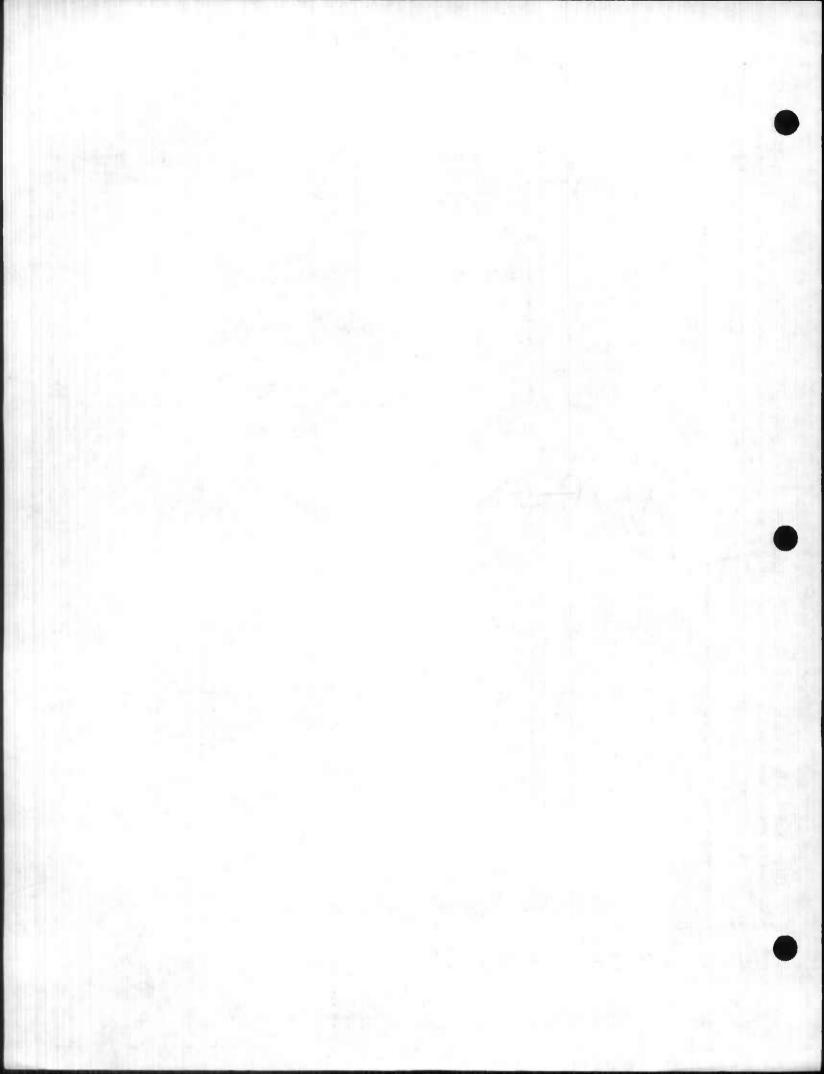


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2 6 8 3 0

	Certificate of Deal	th	Reg. No.	_0000
	Decedent's Name (First, Middle, Last)	2. Dete of I		3. Time of Deeth
Physician /Medical	Andrew Joseph Stracka	A060	- 1/ 2	4111111
Examiner		, Town, or Location of De	ath 4c. County of I	
	Doctors Community Hospital La	nhan	Prince	Georges
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hour 209-10-0360 152 M 2 F 94 Yrs.	ors Min. S. Dete of E. Month, June	3, 1906 1	Birthplace (State or Foreign Country) MCKEES ROCKS, PA
2 .	Usual Rasidence of Decedent			L
aryta above	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes ※☐ No
or 28s-f s be notified	MD Prince George Bowie			
Die Die	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	it Country?
all all and and and and and and and and and and	3720 Idolstone Lane 20715		USA	
at, or ham Examinac: by Fune	11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forcas? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexical Status 1 Yes, Sive Year or Dates:		Specify:	American Indien, White, etc. White
2 ho	15. Decedent's Education 16a. Decedent's Usuel Occupation		16b. Kind ot Busin	ess/Industry
ed within 72 ho ygiens. wer than "nature it, the Medical. Completed	(Specify only highest grade completed) (Give kind of work done during not life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+)	most or working		
The the	4 Steelworker		Steel	Company
thirty dother event	17. Fethar's Neme (First, Middle, Last) 18. Mo	lother's Neme (First, Midd	lle, Maiden Sumeme)	
Menta Menta file e file e	Joseph Stracka	Mary Ference	hik	
pun m	19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Nut	umber or Rural Route Nun	nber, City or Town, Sta	nte, Zip Code)
1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	John A. Stracka, Sr Son 3720 Idolstone	Lane Bowie,	MD 20715	
rages in an in a serie of the control of the contro	20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stele 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other place) Westmoreland County Memorial Park	8/7/00	20c. Location - Cit Greensbu	
The same	21. Signetury of Funerel Service Licensee 22. Name end Address of Fe Metropolita	ecility1_C		
STEE	1	A 22310		
	23a. Per Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such	Approximele		
	shock or heer failure. List only one cause on each line.	in oo ourgino or roophotory	011001,	Intervel Between Onsat and Deeth
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xaminer	disease or condition a. PUL MONARY ZIM HOLISTAN	Immedicts		
6	Due to (or as a consequence of):			1.000
nsit C	6. CONCESTIVE HEART FAIL	ne		14 1311-42
iclan and burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): LIP FARTURE Due to (or as e consequence ot):			1. 24
	cause. Enter Underlying Cause (Disease or injury that injured events			6 11179
	resulting in death) Last	constrhe,	2	4 DAYS.
attendin for use				
ed by the detached	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Po			bute to the cause of death?
igned by be detac	DIMETES		□ Yes 2 TNo 3	□ Probably 4 □ Unknown
m 70 77		24a W	as an autopsy 2	24b. Were eutopsy tindings
should should	URIVAN TRACT INFECTION	pe	formed?	avsilable prior to completion of cause of deeth?
has be 2 s				of deeth?
Page Com		1[Yes 20 No	1 ☐ Yes 2 ☐ No
ector Be	25. Was case referred to medical 26. P	Place of Death (Check on	y one)	
T Sign	1 Pras 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	Nursing Home 5 Re		
After the funeral fune	27. Manner of Death 1 ☐ Neturel 5 ☐ Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?		e how injury occurred	
ector: After by the fune iffication	2 Accident investigation M 1 Yes 2		_1	
rector: n by the	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify)	28f. Location City or	(Street end Number Town, State)	or Rural Route Number,
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
within 24 hours after death. To the Funeral Director After tompletally filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, determined to the basis of examination end/or investigation, in my opinion, and manner steted.	te end plece, end due to to deeth occurred et the time	ne cause(s) and mann e, date and place, sno	er as stated. I due to the cause(s)
Within Comp	29b. Signature and title of certifier 29c. License numb	ber	29d. Date signed (i	Month, Dey, Year)
6	May Sitt non Du	4/240	08/05	/03
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) NORMAN SMILL MD 2905 MITCHELLO	110-40	-/-/	20716
	NORMAN SMIR MD 2905 MITCHELLO	V.16 RD	#104	Bours Mis
State		11 6 1-10 1	1	20010 1. 1
State Registrar	31. Dete filed (Month, Day, Year) 32. Pegistrar's Signature 6. Spouls			
ricgistral	OF HULL (COOL)			

State of Maryland / Department of Health and Mental Hygiene

									Death			Reg. No.					
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Physician /Medical	Robe	rt Raymor	nd Sw	veeney							August	Day			8:2	O PM	
Examiner	4e Facility	Neme (If not institu	ition, give	e street and nu	ımber)				4b. City, To	wn, or Lo	ocation of Dea						
	Subu	rban Hosp	ital						Bethe	sda		Mo	ontg	omerv			
uneral	5. Social Se	ocurity Number	6. S		7. Age (In yrs.	last birthda	(y) If Und	er 1 Year S Days	If Under Hours	24 Hrs. Min.	8. Date of B				ce (Stete	or Foreig	
irector		07-6498 dence of Decedent		™ 2□ F	79	Yrs.	MONTH	Days	Hours	IVIIII.	August		920				
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to the	Maryla	and Mont	gome	ery	Be	thesd	a							101	1 □ Ye	s 27 No	
be notified at Director	10e. Street	and Number					10f. Z	ip Code				10g. Citi:	zen of W	hat Country	y?		
		Rising R	didge	e Way				208	317			Unit	ted	ounty of Death Intgomery 9. Birthplace (State or Country) 100. Inside City 1 Yes In of What Country? 20. States Race - American Indien, Black, White, etc. 101. Black, White, etc. 102. Black, White, etc. 103. Black, White, etc. 104. States 105. Race - American Indien, 106. Black, White, etc. 106. Business/industry 107. State - American Indien, 108. Black, White, etc. 108. Black, White, etc. 109. Black, White, etc. 109. Black, White, etc. 109. Black, White, etc. 100. Black, Wh			
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any is	21. Signatu	ure of Funeral Servi	7		_M006		Rockv:	ille,	Inc.	300	ert A. West land 2	Monte	gome	ry Ave	enue	Home,	
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State of Maryland / Department of Health and Mental Hygiene

							Ce	rtificat	e of	Death			Reg. No.	0 2	0006			
в	Physic	ian	Decedent's Name	(First, Middle, La	ist)							2. Date of De Month	Day	Year	3. Time of Death			
	/Medi		WILLIAM	THOMAS								August)	5:05 p.m			
	Exami		4a Facility Nama (# /	not institution, gi	re street and ni	imber)				4b. City, To	wn, or Loc	cation of Deat	h 4c. County	of Death				
			11808 F1	lora La	ne				N	litche		11e	Prince	Geo	rges			
	Funeral		5. Social Security Nur	mber 6. S	Sex XOXM 2□ F	7. Age (In y	rs. last birthday,	Months	1 Yaar Days	If Under :	24 Hrs. Min.	8. Data of Bir (Month, Da	rth av Yearl	9 Birthpl	ace (State or Foreign			
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	deeth with the Maryland me 23a or 28a-f show mast be notified at	-	11808 F1c	ra Lane				207	21				UNITED	STATI	ES			
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Ĕ	Page min m		1) Burial 2 Cremation 3 Removal from Stata 4 Donation 5/Dother (Specify) Glenwood Cemetery										0 Wash	n	C			
Baltimore	Department Department Important: any Injury o		21. Signature of Fylia	oral Servige Lifty	nsue 1 /	111		2. Nama an				11 200	Tu Hushi		•			
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	/Medical		Immediate Cause (Fi	inal										Day Year , 2000 3. Tima of Death , 2000 5:05 p. 4c. County of Death Prince Georges Bar) 9. Birthplace (State or Fore Country) 22, 1908 Virginia 10d. Inside City Lim NXYas 2 ln 14. Race - American Indian, Black, Whita, atc. African American b. Kind of Business/Industry Private iden Sumama) Dity or Town, State, Zip Code) Chs. MD 2074.3 c. Location - City or Town, State thierval Between Onsat and Death Country Buttons 1 and Death 1				
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Division	or Attending after death. Director: After d in by the fund	Certification:	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not b	8 00 Die	e of Injury - A	t homa, farm, st					8f. Location /	(Street and Numi	ber of Rura	l Route Number.			
Ä	a 등 등 등	Te	4 Homicide	determined	build	ing, etc. (Spe	cify)						wn, State)					
	t hours a unerel D siy filled		29a. Certifier	Cartifician Di	welcles: To the	haet of meet	roudodoo doot	h accurred	at the ti-	na data an	d place o	nd due to the	courselst and -	anner an at	ated			
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Rochelle S. Hardy, M.D. 31. Data filed (Month, Day, Year) AUG 1 0 2000 Registrar

12172 Central Avenue., Mitchellville, Maryland

30. Nama and address of person who completed gause of death (Item 23a) (Type, Print)

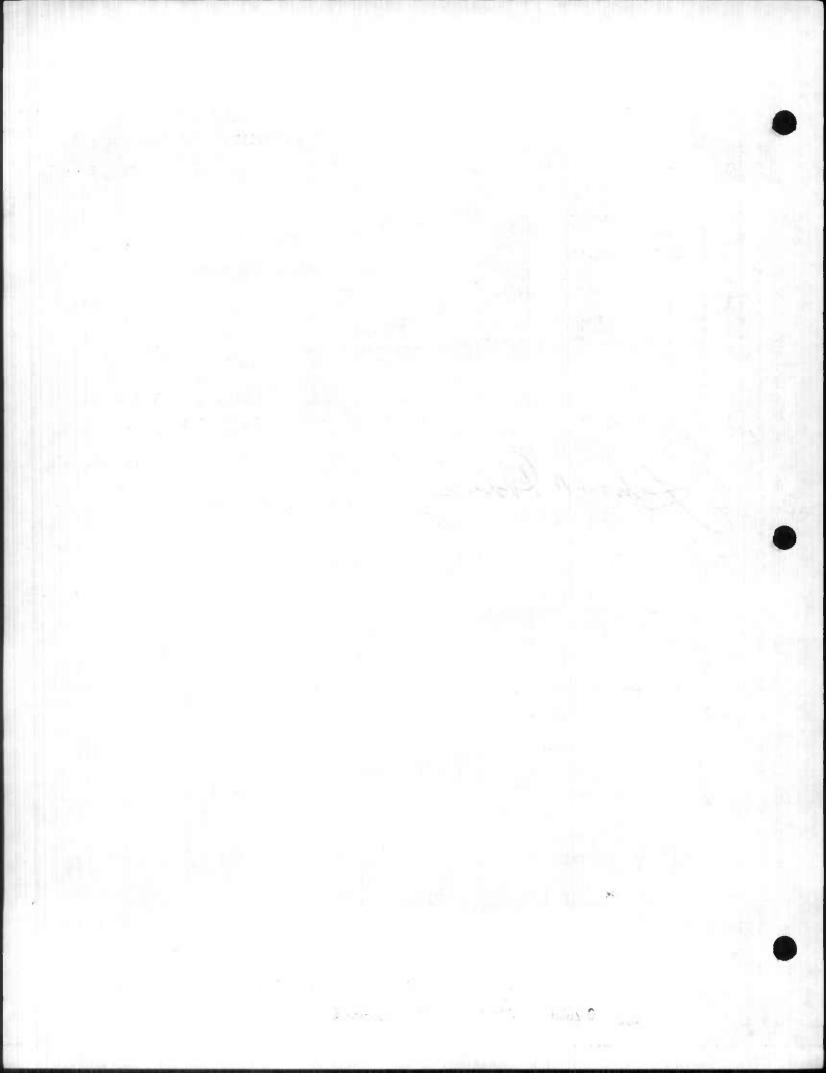
29c. Licensa number

D37391

29d. Data signed (Month, Day, Year)

20721

8/7/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 Decederal Name (First After)	(act)		Cei	tificate	of Deat	h	2. Date of De	Reg. No.		3. Time of Deeth	
Physician /Medical		. TAY						Month	Day 2	Year 5000	08 47	
Examiner	4a Facility Nama (If not institution With Hope And	give street and n	umbar)				Town, or Lo	ocation of Deat		of Death	ent	
Funeral Director	5. Social Security Number 218-38-5178	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Months I	Yaar If Und Days Hours	ar 24 Hrs. Min.	8. Date of Bir (Month, De Aug. 3	th y, Year) , 1942		olaca (Steta or Foreign 11ry) 1and	
	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo						1	0d. Inside City Limits X□ Yes 2□ No	
nter raut be notified	MD P.G 10e. Street and Number 15607 Henrie			COREC	101. Zip C	ode 20607			10g. Citizen of 1			
d other than "natural; or items 23s or 28s-f show event, the Medical Exertines rural be notified at Be Completed by Funeral Director	11. Maritai Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was De Armad F	cedant Evar in U, Forces? 2 100		1	nt of Hispanic (y Cuban, Mexic		ecify Yes or No Rican, etc.)	9- 14. Rac Bla Specify	e - Amaricok, White,	etc.	
nt, the Medical E	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t grede completed	(1-4or 5+)	(Give life. I		done during m retired)	ost of work	ing	16b. Kind of B		dustry	
Imatic event, trail. To Be Comp	12 17. Father's Name (First, Middle, Jennessee Ta			Tru	ck Dr	18. Mo		e (First, Middle Dunni	, Maiden Sumen			
T.	19a. Informant's Name/Relations	hip (Type, Print)	e 1			Street end Nun	nber or Run	el Route Numb	er, City or Town			
important: If Itam 27 i any injury or other tr once.	Doris M. Taylor/wife 15607 Henrietta Dr. Accokeek, MD. 2 20a. Method of Disposition 20b. Place of Disposition (Neme of cematery, cremetory or other place) 4 Donation 5 Other (Specify) 20c. Location - City of Claremont Cemtery 8/12/00 Mechani											
importa any inju pnce.	Burial 2 Ucremation 3 Hemoval from Stata											
hysician and Medical aminer dical Examiner	23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
ed by the attending p detached for use es / Physician/Me	Part II. Other significant condition			ulting in the u	nderlying cau	usa given in Pa	irt I.				o the cause of death?	
	Chacarons of	MANON	9(4					24a. Was	Yes 2 No	24b. W	ere autopsy findings	
page 2 should		4						10	Yas 20 No		ompletion of cause death?	
this certifical director	25. Was case referred to medical axaminer? Hospital: Death (Check only one)									fy)		
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 Actident 5 Pendin investig 3 Sulcide 6 Could determ	not be 28e. Pia	ca of Injury - At ho	Injury ome, farm, str y)	М	1 ☐ Yes 2	□ No		(Street and Num wn, Stete)	ber or Run	el Route Number,	
To the Funeral I completely filled	(Check only and Madical		ne best of my kno basis of examina anner stated.	wledge, death tion end/or in	vestigation, in	n my opinion, o	death occur	and due to the red et the time	, dete end place	and due t	o the ceuse(s)	
0100	29c. License number 015236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANUIT / WARGOUS, MIO. 11125 (ROCK) THE PIKE, RE							AUGUST 4, 2000				
15)	30. Name and address of person CARU I / MAR	Gollo, 1			Print)	us pi	100 , CO	Lockin	UT, 140	20	352	
State Registrar	31. Date filed (Month, Dey, Yeer) AUG 0 9 20		Registrar's Signa	B	Span	all i						



Applied Agency

To the Hospital within 24 hours a To the Funeral C

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

and address of person who completed cause of deeth (Item 23a) (Type, Print)

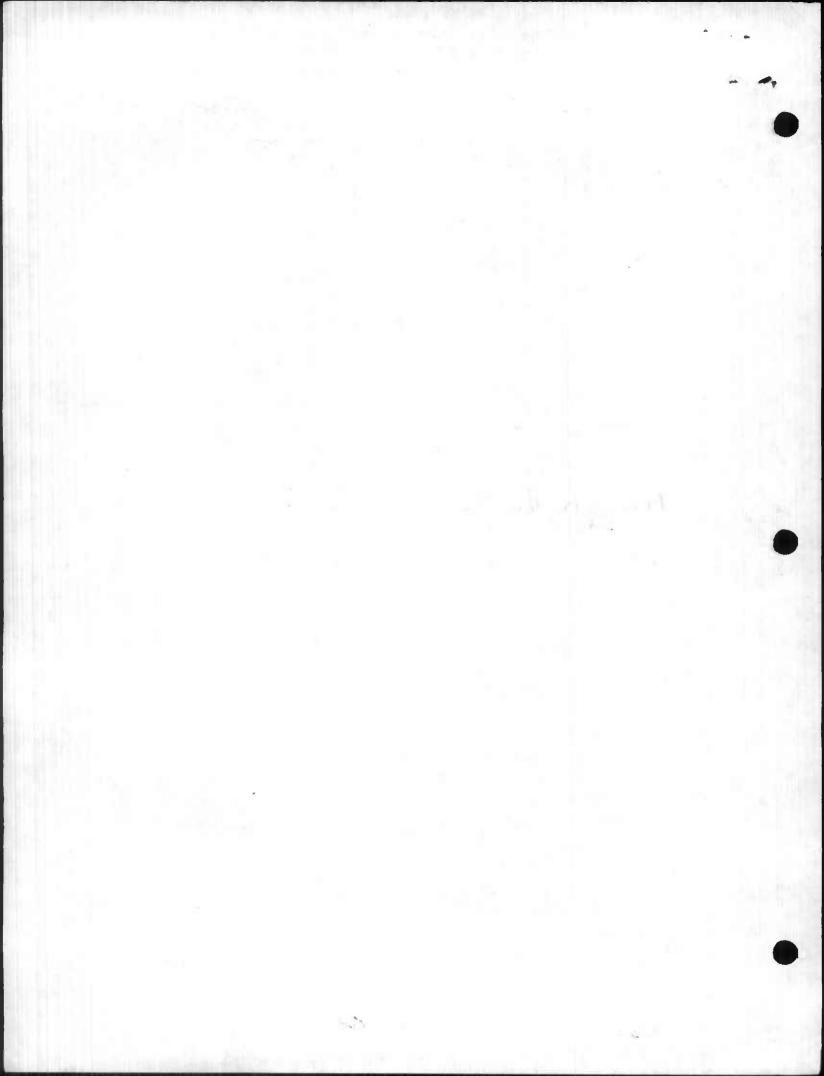
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111 Penn Street, Baltimore, Maryland 21201

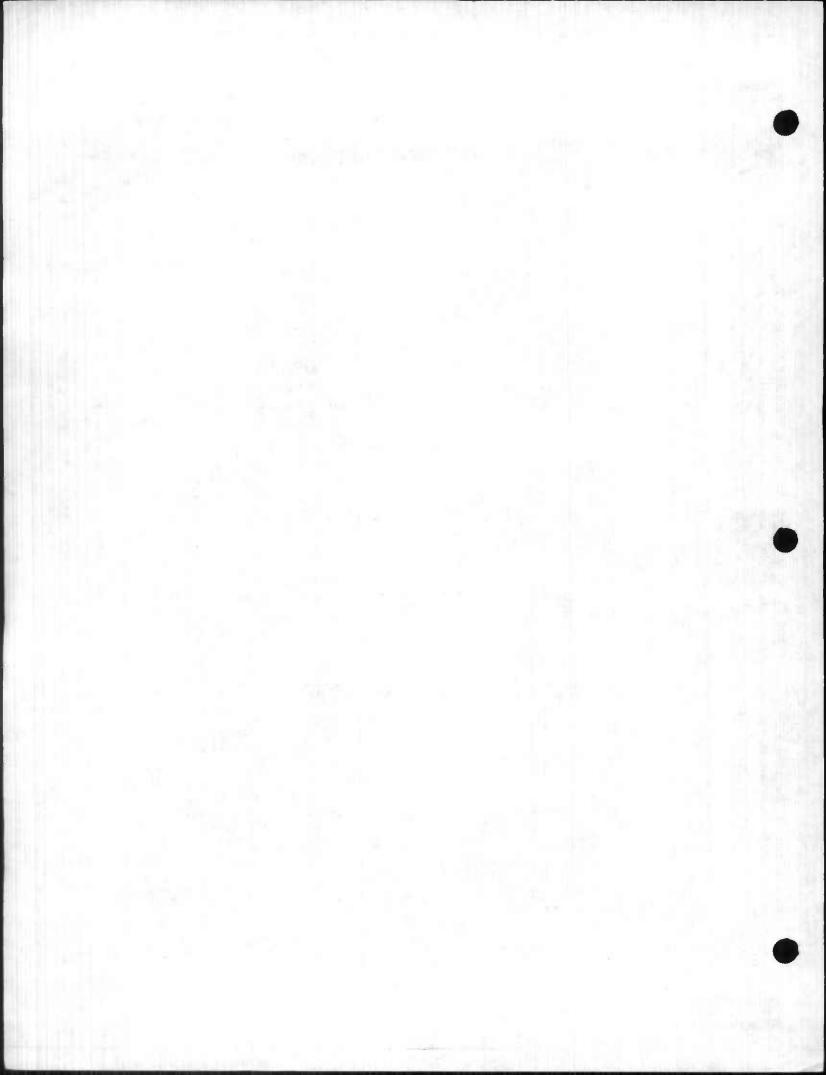
August 15, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedent's Name ((First, Middle, Las	st)		11/5			2. Data of Dea			3. Time of Deat
10.0 11 1	Shige	haru Tal	kahashi					Month	5, 2000	Yaer	4:26PM
/Medical Examiner	4a Facility Nama (If n			9r)			4b. City, Town, or L		4c. County		
LAGIIIIICI	Subur	ban Hos	oital				Bethes	da	Mont	gomer	V
Funeral	5. Social Security Nun			Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			e (Stata or For
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ě u	Usual Residence of D 10a. State 1	10b. County		10c. City	, Town or Lo	cation				10d.	Insida City Lir
te di	Maryland	Montgome	ery	Rock	cville						1 X Yas 2 □
be notified at Director	10e. Street and Numb		-			10f. Zip Coda			10g. Citizen of V	Vhat Country	7
	13007 Clev	reland D	rive			21	0850		United	State	2 9
iner matt	11. Marital Status		12. Was Deceda	nt Ever In U,S	3. 13.		lispanic Origin? (Sp an, Maxican, Puerto	ecify Yas or No-		a - Amarican	Indian,
or its	1 Nevar Married		Armed Force 1 (X) Yes 2 If Yes, Give Year or Date	LILITI		Yes 2 No	Specify:	HICAN, etc.)		k, White, atc	
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marke event, the Medical. To Be Completed	17. Father's Name (Fi						18. Mother's Nam		Maiden Sumam	10)	
To atte	Shigetaro	Takahas	shi				Hana Mo	rikawa			
	19a. Informant's Nam				19b. Mallir	g Address (Street	and Number or Rui	ral Route Numbe	r, City or Town,	State, Zip Co	ode)
Though a like of the street of	June Takah	nashi/Wii	fe				nd Drive,	Rockvil	lle, Mai	cyland	20850
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7 2000 4c. County of Death Elias W. Teetz 4b. City, Town, or Location of Death 8:35 pm /Medical 4a Facility Name (If not institution, give street and number) Examiner Silver Spring Mo If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Holy Cross Hospital Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye **Funeral** Months Days 1⊠M 2□ F Director 140-38-3728 53 June 29,1947 Pennsylvania Usuel Residence of Decedent with the Meryland 10a. State 10b. County 10c. City. Town or Location **ehow** 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours effer death with the Meryla nent of Health and Mental Hyglene.

ant: If Item 27 Is marked other than "natural", or Items 23s or 23s-f ehou ury or other treumstic event, the Medical Example must be notified as 1 Yes 2 No Director Maryland Montgomery Rockville. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Funeral 10401 Grosvenor Place #922 20852 12. Was Decedent Ever in U.S.
Armed Forces? Unknown
1 🖫 Yes 2 🔲 No
It Yes, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier Postal aitlmore. Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Unknown Teetz Unknown Unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10401 Grosvenor Place#922, Rockville, MD 20852 e of Disposition (Name of Date 20c. Location City or Town, Stete Rick Lentz/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Department of Important: If any Injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) 8/8/00 Metropolitan Crematory Alexandria, VA 21. Signeture of Funeral Service Li 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

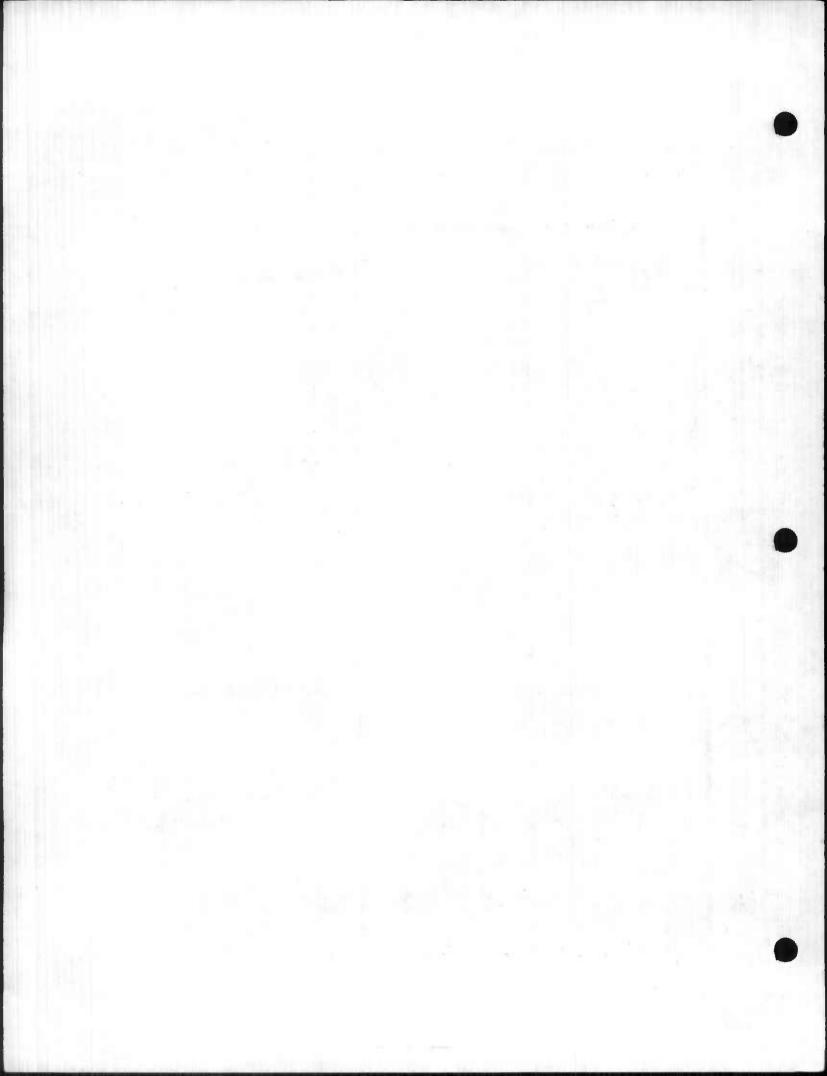
Applications full eral Home, Inc.

500 University Blvd., W, Silver Spring.

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 20901 Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) a Hepatic Failure 2 weeks Examiner Due to (or as a consequence of): Examiner Metastatic Esophageal Cancer 2years The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Pug P.O. Box 68760. physician Physician/Medical the Due to (or es a consequence of) USA BS for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown pericardial effusion Records, à 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? hes page 2 certificate 1 Yes 2 No 1 Yes 2♥ No Division of Vital or Attanding Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ TER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 ⊠Netural 2 ☐ Accident 5 Pending investigation ofter deeth.

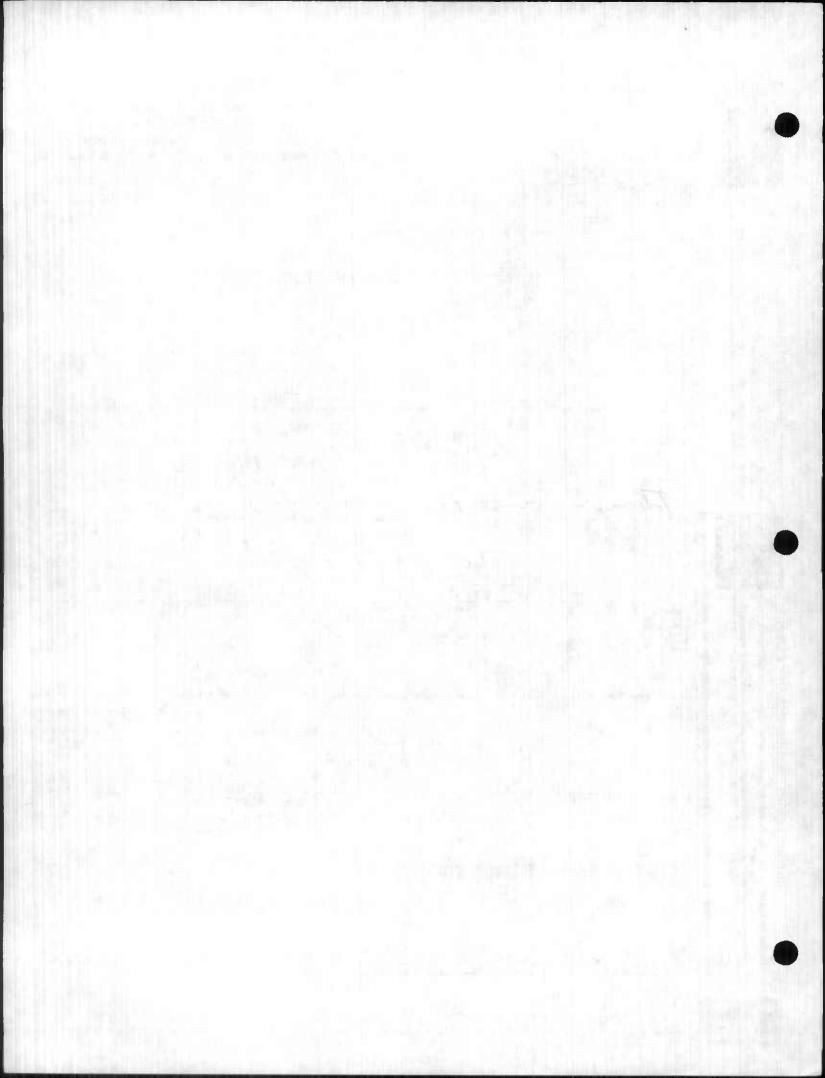
Director: After deeth. 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier completely 29c. License number 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) de D 35996 August 8, 2000 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Burrell, MD 2730 University Blvd., #400 Silver Spring, MD 20902 31. Date tiled (Mooth, Day, Year) AUG 09 32. Registrer's Signature State 2000 Registrar



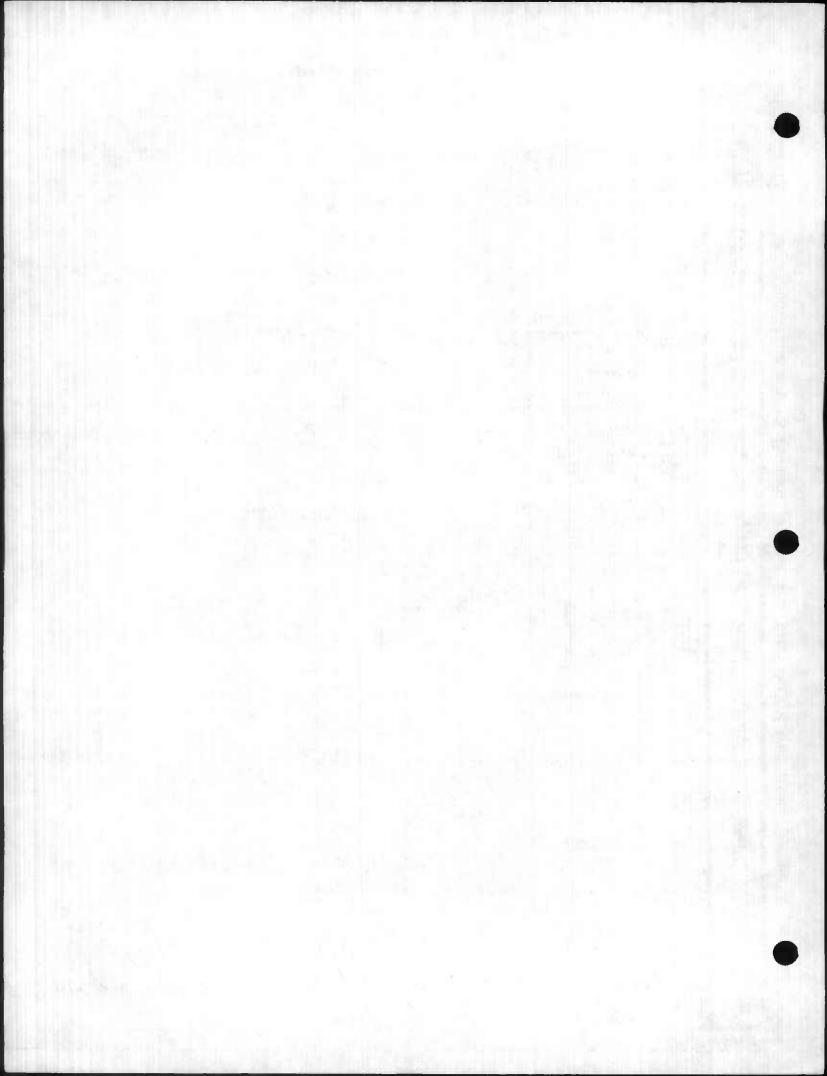
State of Maryland / Department of Health and Mental Hygiene 00 26837 Certificate of Death

		1. Decedent's Name (F	irst, Middle, Las	t)			1111041		20411		2. Date of Dec			3. Time o	f Death
	Physician /Medical			Phy11	lis H	lamilto	n	Th	ompsor	n	August	3 20	000	2:00	P.M.
	Examiner	4a Facility Name (# no			er)				-		ocation of Death	4c. County	of Death		
			kridge V								pring		tgon		
	Funeral Director	5. Social Security Numb	165	9X 7. □ M 20% F	Age (In yrs. 91	last birthday) Yrs.	Months Months	Days		Min.	8. Date of Birt (Month, Day Sept. 6	y, Year) 1908	9. Birthi Cour Kan	place (State of htry) Sas	or Foreign
	1 1.	Usual Residence of De 10a. Stata 10	b. County		10c. Cit	ty, Town or Lo	ocation						1	0d. Inside C	ity Limits
	Mary Hada find a	MD I	Montgome	ery	151			Si	lver S	Spri	ng			1 🗆 Yes	2⊠ No
	with the Maryla to cr 28a-1 show be notified at Director	10e. Street and Numbe	r				10f. Zij	p Code				10g. Citizen of V	/hat Cou	ntry?	
	E E2 3	15210 E	lkridge	Way					20	906			USA		
20	, or hams camber m.	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? \$\infty No		Was Dece If Yes, spe 1 Yes				ecity Yes or No- Rican, etc.)	14. Race Blace Specify	k, White,	can Indian, etc. hite	
8	thorn cal E	15.	Decedent's Ed	ucation	ъ.	16a. Dece	dent's Usu	al Occu	pation			16b. Kind of Bu	siness/In	dustry	
215	ed within 72 ho yglens. er then "netur 4, the Medical. Completed	(Specify of Elementery/Seconde	only highest grad	de completed) Coilege (1-4)	or 5+)	(Give	kind of wo DO NOT u	ork done ise retire	during most	t of work	ing				
2	Corr			1		Но	memak	cer	1				n Ho	me	
Maryland 21215-0020	Manual be fill whental H inches oth info even	17. Father's Name (First Charles 1		ı					-		e (First, Middle, Low	Maiden Sumam	e)		
Aar	O mand	19a. Informant's Name										er, City or Town,			
	s 1 and 7 Health flam 27 other tr	Valerie Wi		- Daugn	-	Place of Dispo			Road		Silver Spring, MD 20906 Date 20c. Location - City or Town. State				
altimore,	Sages ent of E III III	1 Burial 2 C	remation 3 🗆		ite	klawn	matory or	other pla		8	Date 20c. Location - City or Town, State Rockville, MD				
altir	and and and and and and and and and and	21. Signature of Funera			Lai							vler's S		TID .	
ä	F S S S S S S S S S S S S S S S S S S S	Moms	330	Dan	Bal							ton, D.		20016	
		23a. Part1. Enter the di shock, or heart fa	lisease, or comp	olications that cause on each	sed the deat	th. Do not en	ter the mo	de of dy	ing, such as	cardiac	or respiratory a	rest,		Approxima Intervei Be	
	Physician	and the second			0			./		-	0			Onset and	Death
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	al	a	Lon	assa	no,	He	ost &	tou	une			3400	2105
	b b				Due to	as a conse	quenca of)	:							
	executed in and inal-transit	Sequentially list conditi	ione	b. ———	Due to (c	or as a conse	quenca of)	:					1		
0		Sequentially list conditi if any, leading to imme- cause. Enter Underlyir Cause (Disease or Inju- that initiated events	diate				,								
68760	nding physicia use as the bu	that initiated events resulting in death) Last		C	Due to (c	or as e consec	quence of):	:					1		100
ox 6	certificate ding physise as the			d									i		
Bo											l en min				44.40
P.O.	es that the death igned by the atte be detached for by Physicia	Part ii. Other significar	nt conditions co	intributing to death	n but not res	sulting in the u	inderlying	cause g	iven in Part t	•	236. Dia	Yes 2 No	1	bably 4	
	and is that so det											21			
Records,	v requires that the been signed by th should be detache leted by Phys											an autopsy rmed?	a\	ere autopsy vailable prior	to
ec	Pie Pie				HO.	97 P							of	ompletion of death?	cause
E H	cate har page.										10	Yes 20 No	1	☐ Yes 2☐] No
Vital	Physician: The rail director, page TO Be Co	25. Was case referred examiner?	-	Hospital:				- 0	ther		h (Check only o				
of	2 0 0	1 Yes 20 No		1 ☐ Inpi		ER/Outpatie		OA Inju	4 🗆 140	irsing Ho		denca 6 Oth		fy)	
lon	offing ith. : Afte e fund	1 Avatural 5	Pending investigation		Day Year)	Injury	М		ork? Yes 2	No					
Division	tal or Attending P is after death. al Director: After t led in by the funers Certification:		Could not be determined	288. PIBCB OT	Injury - At h etc. (Specil	28f. Location (Street and Number or Rural Route Number, City or Town, State)					n <i>ber</i> ,				
	To the Hospital or Attending Ph within 24 hours stated death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier Check only one) 29a. Certifier (Check only one) 39a. Certifier (Check only one) 3											s)		
	To the comp	29b. Signature thig falls of certifier 29c. License nu								,		29d. Date signe	d (Month)	Day, Year)	
	10	1/150	60/	Bala	Ma		5	7/11	458	>	4	regest	8	2000	
		30. Name and address		- /				1100				Som	,		
		Thomas F.				GA A	ve.	#304	+ OL	ney,	MD 2	0832			
	State	31. Date filed (Month, D	G n n o		istrar's Signa	A LA	1	200	61						



State of Maryland / Department of Health and Mental Hygiene

				Certif	ficate of	Death	Re	g. No.	U 26	838			
Ph	nysician	Decedent's Name (First, Middle, La: Mildred Ruth	Townse	nd			2. Date of Death Month Day Year 3. Time of De						
	Medical kaminer	4a Facility Name (If not institution, give	e street end number)			4b. City, Town, or	August Location of Death	10, 200 4c. County		5:30 am			
		Spa Creek Center				Annapolis	3	Anne A	rundel				
	neral ector	5//-01-2447	DM aNE		Under 1 Yea Ionths Day	r If Under 24 Hrs	8. Date of Birth (Month, Dey, Oct 28,	irth 9. Birthplace (State or Foreig Country)					
yland	¥	Usual Residence of Decedent 10a. State 10b. County	10d. In	side City Limits									
Pa-f a	ctor	Maryland Anne Aru		☐ Yes 2 No									
death with the Maryland	I Director	10e. Street and Number		10g. Citizen of What Country?									
5 2	edical Examiner must be notified at leted by Funeral Director	45 East Lake Drive 11. Marital Status 1 Never Married 2 Marned 3 DWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 Wo If Yes, Give Year or Dates:		21403 s Decedent of es, specify Cu Yes 2 No	Hispanic Origin? (Suban, Mexican, Puer Specify:			e - American Inc k, White, etc.				
21215-0020 d within 72 hours alt giene. rr than "natural", or	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent	t's Usual Occ d of work don NOT use retii	e during most of wo	rking	16b. Kind of Bu	siness/Industry				
212 within	omp	Elementary/Secondery (0-12)	College (1-4or 5+)	Homemak		90)		Own_Hom	e				
D PE	Be C	17. Father's Name (First, Middle, Last)		A		18. Mother's Ne	me (First, Middle, A	feiden Sumam	iden Sumame)				
Baltimore, Maryland () permit. Pages 1 and 2 should be filed Department of Health and Mental Hyp Important: If tem 27 1s marked other	To	William Rogers	110	1			Bird Mah		0 To 0	1			
Mal d2 st d2 st d2 st d2 st d2 st	2 6	19a. Intermant's Name/Relationship (et end Number or R				,			
re, 1 an Heal	other	Faith Townsend/ I 20a. Method of Disposition	20	b. Place of Disposition	on (Neme of			is, MD 21403		itata			
Baltimore, semit. Pages 1 at Department of Heal moortent: If item:	ny or	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal trom State	cometery, cremete Rock Creek		1	8/15/00	Washing	ton, DC				
Salti smit. spartin	any Inju	21. Signature of Funeral Service	Inc										
m 89 =	6 8	IRACY A.	Francis J. Collins Funeral 500 University Blvd., W, S. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrows.										
Physic /Med Exam	dical	shock, or heart tailure. List only Immediate Cause (Finel disease or condition resulting in death)	a. Cerebrovaso				c or respiratory arre	551,	Onse	val Between et and Death			
	i i			o (or as a conseque									
beta pu	the buriet-transit	Sequentially list conditions,	b. Generalized Due t	Atheroso o (or as a consequer		S			years				
Se age	2 2	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	yea	rs									
	8 8	that initiated events . resulting in death) Last	Due to	o (or as a consequer	nce of):								
death cer death cer	d for u	Part II Other elgolficent conditions o	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?			
that the ed by the	d be detached for use	Part II, Other significant conditions of	onthibuting to death but not	resulting in the unde	mying cause	given in Pait i.	1 🗆 Ye			4 Unknown			
requiper /	shoul						24a. Was a perform		available	utopsy tindings e prior to ion of cause ?			
VITAL Re- Molen: The lay certificate hes	director, page 2						1 □ Ye	s 2NNo	1 ☐ Yes	2 № No			
VITA clan: entific	Be	25. Was case reterred to medical axaminer?	Mosnitel:		10		eth (Check only on	Θ)					
0 & E	To To	1 ☐ Yes 2 ☐ No 27. Manner of Death		28b. Time of	3LI DOA		Home 5 Reside						
DIVISION I or Attending I after death. Director: After	he fune	1 Netural 5 Panding 2 Accident investigation	(Month, Dey Yea	28a. Date of Injury (Month, Dey Year) 28b. Time ot Injury M 28c. Injury at Work? 1 Yes 2 No									
		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of thjury - A building, etc. (Sp	28t. Location (St City or Town		er or Rural Rou	te Number,						
To the Hospital within 24 hours To the Funeral	pletely fill		ysician: To the best of my niner: On the basis of exam and manner stated.										
To the Within	Сотр	29b. Signal ta and title of certitier	- 1		29c. Lice	nse number	2	9d. Date signe	d (Month, Day,	Year)			
	20	1) Beef	Fred ?	n-n-	D)	N965		8/10	100	TAIL			
		30. Name and address of person who	completed cause of death (Item 23a) (Type, Pri	Ridg	ely An	Ann	poks	m	21401			
	State	31. Date tiled (Month, Day, Year)	32. Registrar's Si	gnature 4	land			1					



z, 3 should		
PHILIPPIN DRIVING PAPER 1, 2		
ACTION TO USE AS THE INC.		ce.
or, page 3 should be be		ust be notified at on
III DA DIE LOINER GILLECT	r removal.	redical examiner m
all and confinering lined	r to burial, cremation, o	numatic event, the m
by the attending priysica	and Mental Hygiene prior	/ injury, or other tra
ncate has been signed	State Dept. of Health a	item 23 shows any

BALTIMORE, MARYLAND 21203-314

からた 下った DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY FUNERAL DIRECTOR

ins after death. Page 6 may be retained by the hospital or attending TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely be fined within 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, crema IMPORTANT; If item 28 is marked, or item 23 shows any injury, or other traumattic event,

1	•	FOR STATE REGISTE	RAF
	1, 0	ECEDENT'S	N/

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF D	. TIME OF DEATH					
	HIGH		-	NARD		ULRICH			July 13, 2000				4:30 A M			
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (in yrs. les		IF UNDER	DAYS	HOURS	24 HRS.	7. DATE OF BI (Month, Day	Year)		Country)	ACE (State or Foreign		
e l	220-07-86			89	YRS.						1911		-	yland		
		9e. FACILITY NAME (ti not institution, give street and number)					9b. CITY, TOWN OR LOCATION O							9c. COUNTY OF DEATH Harford		
		Rock Spring Village					Forest Hill					L Ha				
E C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				10c. CITY, TOWN OR LOCATION							*	1	Od. INSIDE CITY		
	MD.		Harfor	d	Jarrettsvil					lle		1	LIMITS?			
	10e. STREET AND NUMBER		101. ZIP CODE							ZEN OF WH	AT COUNTRY?					
FUNERAL	4017	1 Road	1 210					084			U.S	.A.				
5	11. MARITAL STATUS	NT EVER IN U.S. AR	ARMED 13. WAS DECENDENT OF HISPANI							14. RACE -	- American Indian, White, etc.					
BY	3 Widowed A Discovered			17 YES 2 □N WAR OR DATES • 1942	NO If yee, specify Cuban, Maxica 1 VES 2 NO Specify					,,				Specify: Caucasian		
ED		CEDENT'S ED		16a. DE	CEDENT'S	USUAL OC	CUPAT	ON ont of worlds	20	16b. KIND	OF BUSI	NESS/IND	USTRY			
<u> </u>	Elamentary/Secondary (College (1-4 or 5	+) life.	Do NOT u	se retired.)										
COMPLETED	8		steen doors	Navi	gati	Lona	1 5	pec:	iali	Lst	Uni	ted	Sta	tes Navy		
5	17. FATHER'S NAME (First, I	Middle, Last)								ME (First, Middle	, Malden Si	urname)				
BE	Jerome	e		Ulr	_				Nani					lton		
2	19a. INFORMANT'S NAME (- /-							Route Number, Ci				21084		
-	Kathleen I				_	_			_	4	_	_		ville, Md.		
	200 METHOD OF DISPOSIT	TION ion 3 🗆 Ren	movel from State							7/15						
	4 Donation 5 Othe	r (Specify)		Loyd	on 1						Bal	time	ore,	Maryland		
	21. SIGNATURE OF FUNER.	Hlul	ilen K	who	-	1	E. (urt					Home, PA		
CERTIFICATION	IMMEDIATE CAUSE (Fi disease or condition resulting in death) Sequentially list condi if any, leading to immediate. Enter UNDERLY CAUSE (Disease or Injulati initiated events	Itlons, ediete	D (OR AS A CONSE	UL ~	tricu	emila.	c C,	rny	thoris	PAT	rhy		Onset and Desth			
ERT	resulting in death) LA	ST	d		ALEXANDER OF CASE											
	PART II. Other algorific	ent condition	ona contributing to	o death but not	resulting	In the un	derlyk	ng cause	given in	Part I. 24a	WAS AN A			WERE AUTOPSY FINDINGS		
<u> </u>										PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDICAL									1123 2)	KINO		OF DEATH?				
Σ							_									
A	25. WAS CASE REFERRED	TO MEDICAL	T				26. 1	PLACE OF C	DEATH (Ch	eck only one)			_			
200	EXAMINER?		HOSPITAL:	☐ ER/Outpatient 3	DOA	OTHER 4 Num	1:				nothu /	451	nd L	iVINC		
PHYSICIAN:	27. MANNER OF DEATH	27. MANNER OF DEATH 280. DATE OF INJURY (Month. Day, Year) (Month. Day, Year) (Month. Day, Year) (Month. Day, Year) (Month. Day, Year) (Month. Day, Year) (Month. Day, Year) (Month. Day, Year) (Month. Day, Year)														
BY	2 Accident	Investigation		OK IN IT IT		M don't			NO	044 1 00	M. en:					
	3 Suicide 6 4 Homicide												ute Number,			
COMPLETED	const. Only		SICIAN: To the bast of											and menner as stated.		
BE	296. SIGNATURE AND TITL					29c. LIC	3 S S	MBER 285	0.073			Month, Day, Year)				
2	30. NAME AND ADDRESS		PANY M				pH	Ri L	(2S)	Bel A	nn					
	31. DATE FILED (Month, Dep		Z. REGISTS	COLUMN TO THE OWNER OF THE OWNER												
	JUL 17		Bener		14	DOWN	6	•								

the man of hally

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** To, Mary Van Sant Agnes August 2000 8:15 a.m /Medical 4c. County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Nursing and Rehabilitation Ctr. Rockville Montgomery If Under 1 Year Months Days 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2X F 88 1911 Director 219-20-7605 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or floms 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Montgomery Montgomery Village 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9634 Shadow Oak Drive 20886 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: P White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elemantary/Secondery (0-12) College (1-4or 5+) 12 Analyst Federal Government permit. Peges 1 and 2 should be filed to Department of Health and Mental Hygies Important: If Item 27 is marked other 1 any Injury or other traumatic event, it 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Geckle Mary E. Gamble . 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Van Sant -daughter 9634 Shadow Oak Dr., Montgomery Village, Md. 20886 Patricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Aug. 24 2000 1 ■ Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Arlington, Virginia 21. Signeture of Funeral Service Lice 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, Maryland 20910 to or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Pert1. Enter thand shock, or head to Approximate Intervat Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Metastatic disease or condition resulting in deeth) Examiner Examiner ongestive Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest and Due to (or as a consequence of) physician s the burial Obs nchre Box 68760, Physician/Medical Due to (or as e consequence of) attending voidusm Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? ata has been signed by the page 2 should be detached 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Records, É 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No certificata 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case raferred to medical Be 26. Place of Deeth (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier (Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year)

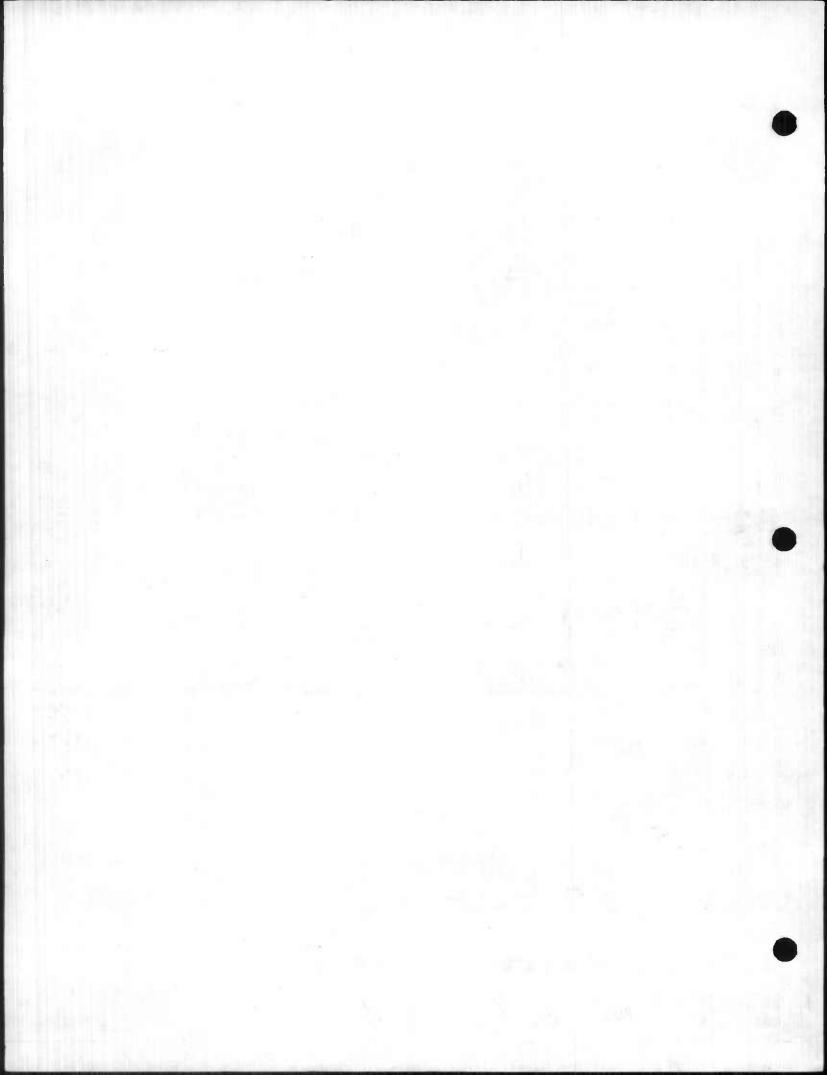
State Registrar

32. Registrer's Signetura AUG 11 2000

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print)

Dr. Sunita Hanjura, M.D.; 809 Veirs Mill Rd., Rockville, Maryland

29d. Dete signed (Month, Day, Year) August 10, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Physician WILEY DARRYL 16:00 P.M. AUGUST 8TH 2000 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner BACTIMORE HOPKINS HOSPITAL JOHNS 8. Dale of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (fn yrs. lest birthday) **Funeral** 15M 20 F Deys Hours Min. 38 Yrs. 557-23-6174 California 4/6/62 Director Usuei Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show MD P.G. Y☐ Yes 2☐ No Accokeek Director r than "natural", or items 23s or 28s-1 the Medical Examiner must be notifi-10g. Citizen of Whet Country? 10a Street and Number 10f Zin Code 101 Beechdale Court 20607 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Yes 2 No 1985 If Yes, Give Yeer or Detes: 1990 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0020 Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Elemantery/Secondery (0-12) College (1-4or 5+) Soft Ware Engineer Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Montal should be Willie Wiley Deborah McClellan 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nant of Health an . permit. Pages 1 and 2: Department of Health ar Important: If fleen 27 is any Injury or other trau once. 101 Beechdale Court Accokeek, Md. 20607 Tonya Wiley/wife 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stale 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Evergreen Cemetery 8/16/00 California 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licenses 3910 Silver Hill RD.Suitland, MD.20746 nuel Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrest, buck, or heart feiture. List only one cause on each lina. Approximete Intervel Between Onsat and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) 6 Hours CARDIO - RESPIRATORY FAILURE Examiner Due to (or es e consequence of) Physician/Medical Examiner INB FOLLICULAR MIXED HON HODGKINS - 16 MONTHS STAGE Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): use as the burial-trai The law requires that the death certificate be axec. Box 68760. AMPHOMA. the ettending physician thet initieted events resulting in death) Last Due to (or es a consequence of): IL GRAFT VERSUS HOST DISEASE. P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown á bengis d be del of Vital Records. þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? page 2 1 ☐ Yes 2 € No 1 Yes 2 No this certificate Physician: 25. Wes case ratarrad to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 10 1 Yes 2NNo 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division Attending 5 Pending Investigetion 1 ☐ Yes 2 ☐ No death. i Director: A 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by or A after 4 Homicida within 24 hours a 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dale end place, end due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. edicai 29a. Certifier 29b. Signature and titig 29d. Dete signed (Month, Day, Year) 29c. License number ales 2090 AUGUST STIT 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State

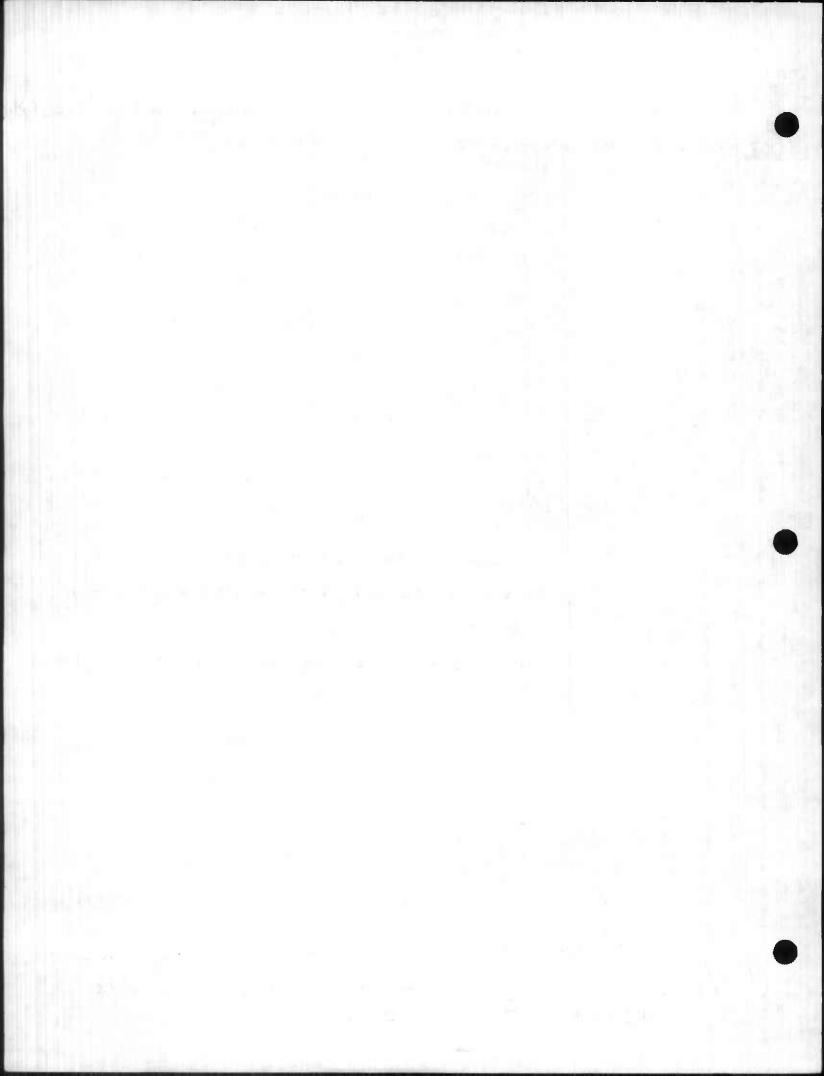
Registrar

31. Date filed (Month, Dey, Year) AUG 1 1 2000

ADETOLA.

Year) 2. Registrer's Signature

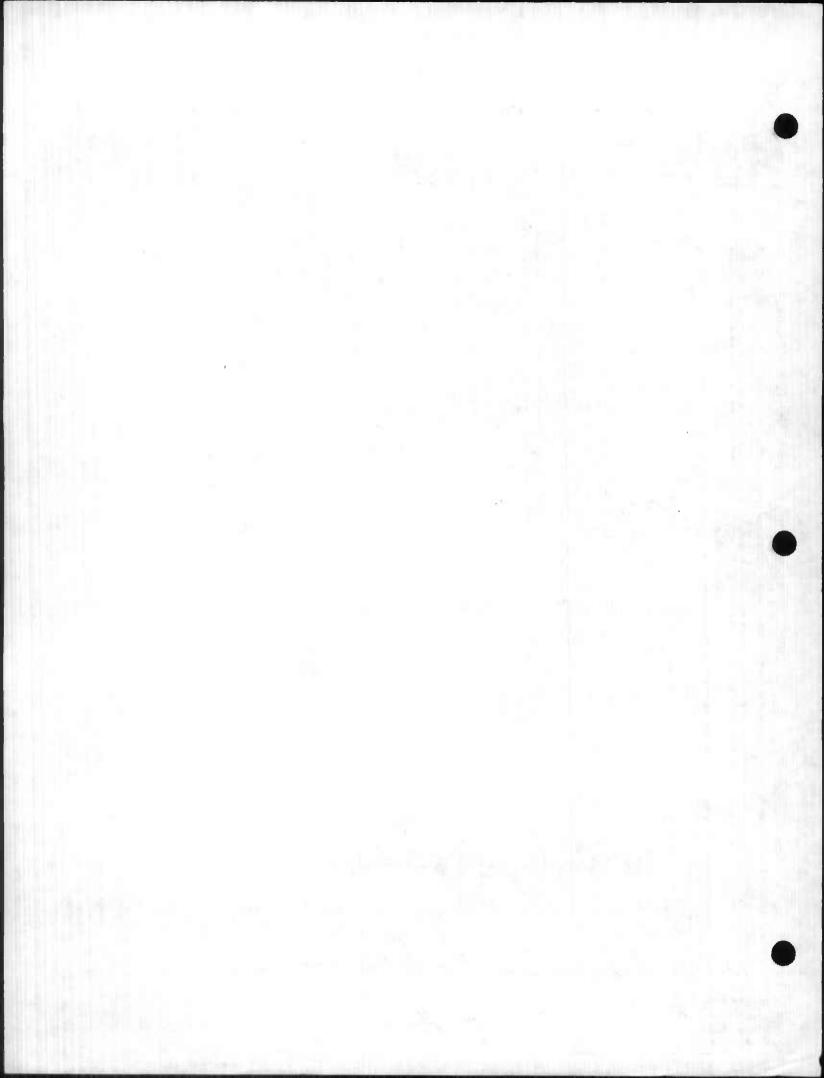
- JOHNS HOPKINS MOSPITAL, BALTIMORE.



mend item	5 per fh G787 9/15/00	State of M	aryland		artment rtificate			ind Me		g. No.	0 2	68	42	
Dhysisian	1. Decedent's Neme (First, Middle, Le								Dete of Deeth Month gust 8,	Day	Year		of Death	
Physician /Medica	Eleonore Maria	Eleonore Maria White										4:30	A.M.	
Examine	8605 Magnolia Drive Lanham									Prince			e Georges	
Funeral Director	216-41-3533 216-41-3533	Sex 7. Age (In yrs. lest birthdey) If Under 1 Yeer Hunder 24 H						Min. Ma	Date of Birth (Month, Day, rch 25,	year) 9. Birthplece (S Cauntry) Neth		ether	e or Foreign lands	
	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City.	, Town or Lo	ocation						1	Od. Inside	City Limita	
f sho		AOTRAS	Lanh										es 2 No	
be notifie	10e. Street and Number	corges	10f. Zip Code							10g. Citizen of Whet Country?				
at be			U.S.A.											
	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 H Yes, Give Yeer or Detes:	7		Was Deced If Yes, spec		ispanic Orig en, Mexican Specify:	gin? (Speci , Puerto Ri	ty Yes or No- can, etc.)	14. Race - American Indian, Bleck, White, etc. Specify: white				
lical J	15. Decedent's E	ducation		16a. Dece	dent's Usue	i Occup	ation	t of working	1	6b. Kind of B	usiness/Ind	dustry		
ygene. ser than *naturn it, the Medical J	(Specify only highest green Elementery/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us					0 0				
		2		Compu	ter P	rogt				S. Gov		ent		
intend off	17. Father's Neme (First, Middle, Last Josef Eder	9	2001				Maria	1/4	First, Middle, M ets	leiden Sumen	10)			
de de de de de de de de de de de de de d	19e. Informent's Name/Reletionship	(Type, Print)		3 65 50					Route Number,		Stete, Zip	Code)		
m 27 her b	Arthur J. White,	Jr./Spouse			Magno osition (Nam		Drive		am, MD		0706 ocation - City or Town, State			
0 = 0	20a. Method of Disposition 1 Darriel 2 ACremation 3 D		CO	metery, cre	metory or of	ther plea	(e)		Date 2					
dary.	4 Donetion 5 Other (Special		rt.											
P T T	22. Name end Address of Fecility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722													
	23a. Part1. Enfer the deliane, or comshock, or heer failure. List only	pplications that cause	d the death.								1	Approxir	nate Between	
ysician Medical aminer	Immediate Cause (Final disease or condition resulting in death)	a. Ovaria		cinom		tast	atic	1977			1	Crisor di	nd Death	
hysician end the buriel-transit	Sequentially list conditions, if any, leeding to immediate	b. —	Due to (or	es e conse	quenca of):						1			
ysician ne buria	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Dunta (a)											
attending phy of for use es the following delice	resulting in death) Lest	d	Due to (or	as a consec	as a consequence of):									
for u									L cor Dida-		. 4 - 15 - 14 - 14	- ^^ -		
achec		Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert f.								s 210 No			Unknow	
should be										performed? ave		ere eutop eilable pri empletion death?	sy findings or to of cause	
0 CI									1 🗆 Ve	s XX No		☐ Yes :	2□ No	
certificate rector, pay							26 Place	of Death /	Check only one					
this certificate he ral director, page		Hospitel: 1 ☐ Inpatie	ent 2 E	R/Outpatie	nt 3□ DC	A Oth			Reside		ner (Specil	(v)		
After this funeral of		28e. Dete of Inju (Month, Da		28b. Time o		8c. Injur Wor		- 1			v injury occurred			
Director:	1 A Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Plece of In		me, farm, st	М	1 🗆	Yes 2□I		28f. Location (Street and Number or Rural Route Num City or Town, State)					
within 24 hours after To the Funeral Dir completely filled in		hysician: To the best miner: On the basis o end menner st	of examineti	rledga, deat on end/or in	th occurred anvestigation,	at the tir in my o	ne, dete en pinion, deel	d plece, an th occurred	d due to the ca let the time, de	use(s) and mote end piace,	enner as s and dua to	stated. o the caus	se(s)	
within 24 hours. To the Funeral completely filled		100	01) /	290	. Licens	e number	145	25	d. Dete signe	d (Month,	Dey, Yea	r)	
(10)	1 Maice	ex w	W	M	(/) D	3517	76		A	ugust 9	9, 20	00		
12)	30. Neme and address of parson who													
	Marcia L. Will,				Center	Dr.	#205	Gree	enbelt,	MD 20	770			
State	AUG 1 (100000 Year)	32. Hegisti	rer's Bignati	ure										

DHMH 16 Rev 6/95

Registrar



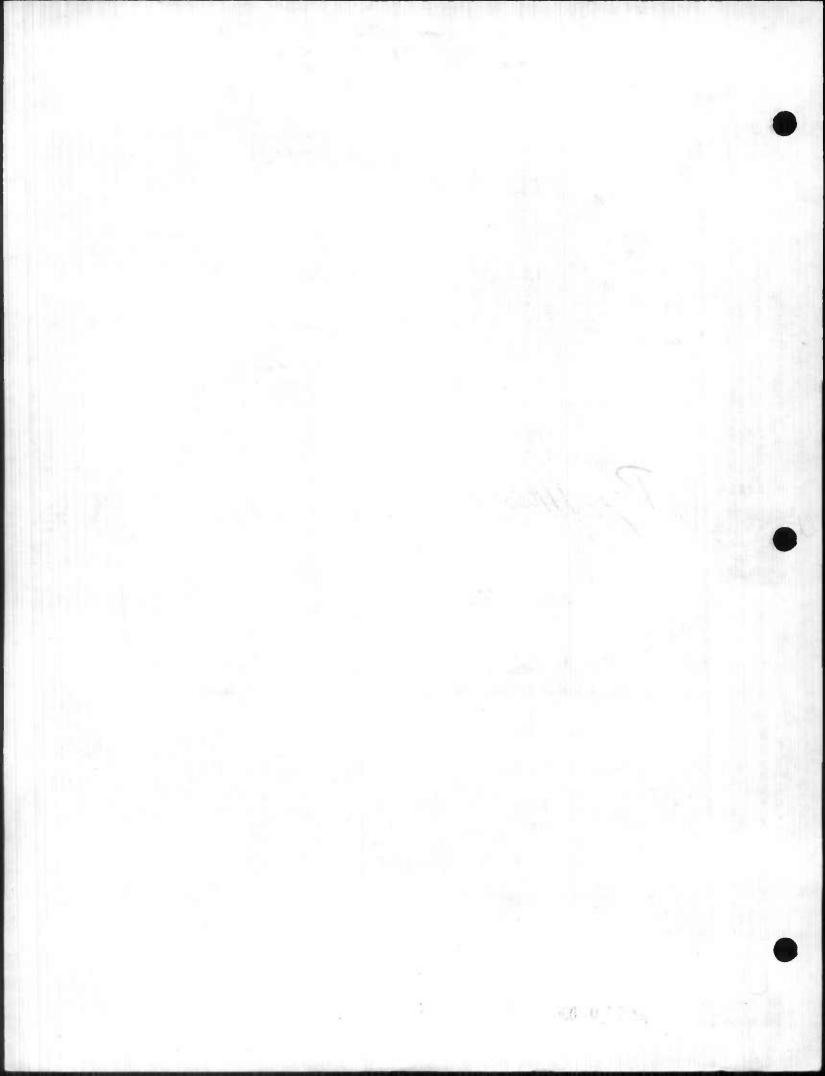
State of Maryland / Department of Health and Mental Hygiene 00 26843

				Ce	ertificate	of Death		Reg	. No.		
		1. Decedent's Nama (First, Middle, La	st)		34110			ta of Death			3. Tima of Death
	Physician (Madical	Man	tha West				Mc	8-6	5 - 2000	Year	1:41pm
	/Medical Examiner	4a Facility Nama (If not institution, giv	a street and number)			4b. City, Tow	on, or Location	of Death	4c. County	of Death	
	LXdiffiller	Laurel Regi			- Willeday V		urel				Georges
	Funeral Director	5. Social Security Number 6. S 246-66-2890 10 Usual Rasidence of Decedant	7. Age (In y	rs. last birthday Yrs.	Months D	ear If Under 2 ays Hours	Min. (M	la of Birth onth, Day, 1		9. Birthpl Count	aca (Stata or Foreign ny)
	e-f ahow direct at	MD 10b. County Prince	Georges 10c.	City, Town or L Lau	ocation rel		,14			10	od. Inside City Limits 1 ☐ Yas 2 ☐ No
	ith with the Ma 23e or 28e-fa art be notified ral Director	13605 England	d Court		10f. Zip Co 20°	de 708		10	g. Citizen of V	What Count	ry?
020	72 hours efter death with the Maryland Instural; or items 23s or 28s-f show deal Earnhar must be notified at seed by Funeral Director	11. Marital Status 1 ☐ Nevar Married 2 ☐ Married ★☆ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yas 2 No If Yas, Giva Year or Dates:	U,S. 13.	Was Decedent If Yes, specify 1 ☐ Yes 2☐	of Hispanic Orig Cuban, Mexican, No Specify:	in? (Specify Ya Puerto Rican,	atc.)		e - Amarica ck, Whita, a	itc.
21215-0020	5 3	15. Decedant's Ec (Specify only highast gra Elemantary/Secondary (0-12)		(Give	odent's Usual O e kind of work d DO NOT use n	one during most stired)	of working	10	Farm:		ustry
0	Hygie other other Feat, II	7 th 17. Father's Nama (First, Middla, Last)				1	's Name (First,	Middle, Mi	aiden Sumam	ne)	
ılan	Vade m	Je	efferson Pu	gh		E	Elbert	a Mod	ore		
Maryland	d 2 should be and 7 is mutant	19a. Informant's Name/Ralationship (Maxine Crider(I				gland C					Code)
Baltimore,	8 6 -	20a. Mathod of Disposition 1		Place of Disponentery, credugh Fa	matory or other		Date		Vance		
Balti	permit. Pege Department of Important: If any Injury or DRCS.	21. Signature of Funaral Sarvice Licen		-	2. Nama and A	ddress of Facility 2nd St	on Br	own]	Funera	al Ho	
	Physician /Medical Examiner Examiner	23a. Part 1. Enter the disease of compshock, or beart failure. If st only immediate Cause (Final disease or condition resulting in death)	Septi	C Shoo	ck quence of): Ulcer					1 1 1 1 3 3 4	Approximate Interval Between Onset and Death
Box 68760,	nding physicia use as the bur in/Medical	Sequentially list conditions, if any, laading to immadiate causa. Enter Undartying Cause (Disease or injury that initiated events rasulting in death) Last	c	(or as a conse						1	
P.O.	y the sched	Part II. Other algnificant conditions of	ontributing to death but not i	resulting in the u	underlying caus	e given in Part I.	2				the cause of death?
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R	The law ate has be page 2 s							1 ☐ Yas	2 7 No	10	Yas ANO
ta	certificate rector, pag	25. Was casa rafarred to medical				26. Place	of Death (Che	ok only ona			2121
>	D G S	axaminar? 1 ☐ Yas 2 ☒ No	Hospital: XIXInpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nur	sing Homa 5	Residen	ce 6 Oth	ar (Specify)
	Attending Phir deeth. actor: After th by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day Year,	28b. Time of Injury	of 28c.	Injury at Work? 1 Yes 2 N		escribe hov	v injury occur	red	
Division	Part I	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicida detarmined	28a. Place of Injury - A building, etc. (Spe	home, farm, st cify)	treet, factory, of	fice		cation (Stre		er or Rural	Routa Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifiar (Check only one) 1 Certifying Physics (Check only one) 2 Medical Example (Check only one)	ysician: To the best of my k niner: On the basis of axam and manner stated.	nowledge, deat nation and/or in	th occurred at the	ne time, date and my opinion, death	place, and du	e to the cau	use(s) and ma a and place,	anner as sta and due to	sted. tha cause(s)
	To the comp	29b. Signature and title of cehiliar	mi -			53411	VE I	29	d. Data signe 8 – 7	d (Month, L - 200	
	(2)	30. Name and address of person who	completed causa of death (fi	tem 23a) (Type,	, Print)						
	1	Jagolish S	nesadri MD	3060 N	1itche	llville	Rd #	103	Bowie	Md	20716

DHMH 16 Rev 6/95

State Registrar

31. Data filad (Month, Day, Year)
AUG 1 0 2000



Please Type or Print In Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26844 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Novella D. Williams August 2000 2:37AM 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 13501 Reid Circle Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Dey, Year) Apr. 26, 1909 5. Social Security Number 7. Age (In yrs. last birthday) Deys Months Hours 578-07-5933 1 □ M 2 以 F 91 Georgia Yrs. Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1√2 Yes 2 No Prince George's Ft. Washington 10g. Citizen of What Country? 10f. Zip Code 13501 Reid Circle 20744 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Rawls Emma Devoe 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Blackbourne - Daughter 13501 Reid Circle, Ft. Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Harmony Memorial Park 8/10/2000 Landover, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetule of Fullerel Service Licensee 22. Name end Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 ewon 10V/2 Frier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Large Cell Lymphoma Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

physician

signed by the atter

should I

page 2 s has certificate

funeral

the

3

filled in

completely

i or Attending Physician: after death. Director: After this certifica

within 24 hours a To the Funeral D Hospitai

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by

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10a State

Maryland

10e. Street and Number

(Unknown)

Funeral

Director

28a-f ahow

items 23a or

6

"natural"

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked other any injury or other traumatic avent bace.

the Medical Examiner must be notified at

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Examiner the buriel-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical

Immediate Cause (Final disease or condition resulting in deeth)

24b. Were autopsy findings eveilable prior to completion of cause of death?

August 4, 2000

24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one)

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 New Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier

(Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

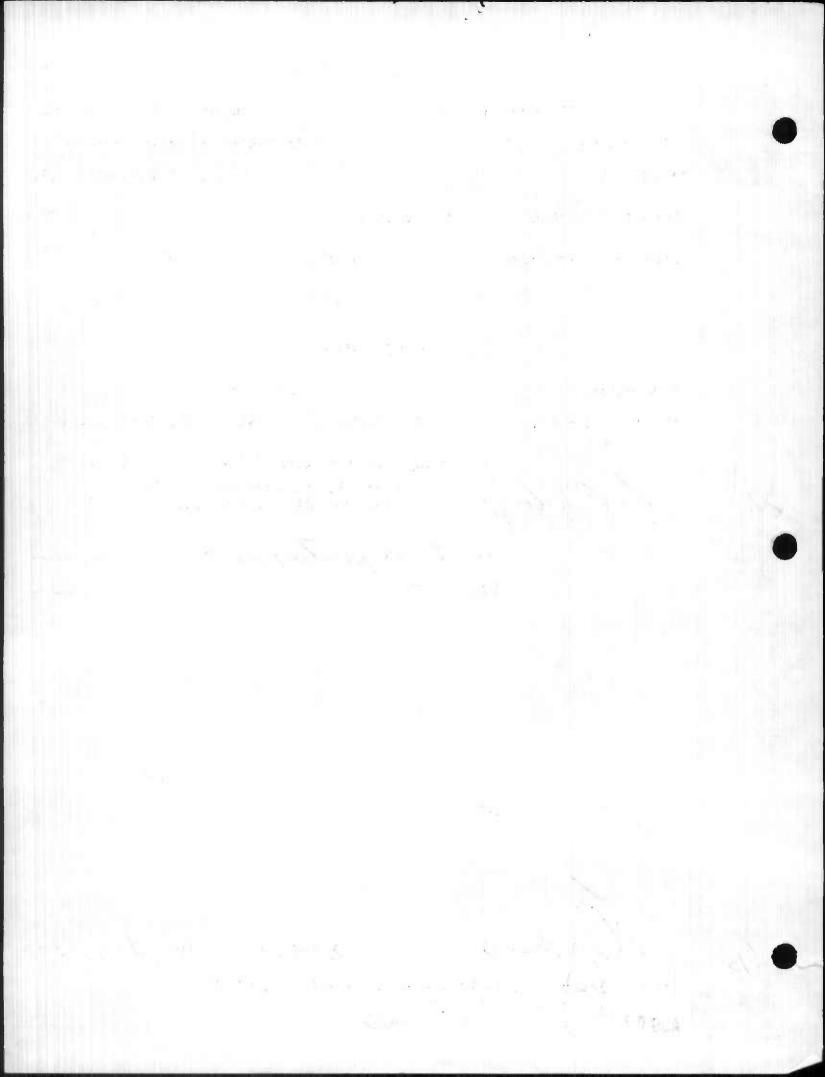
9801 Georgia Ave., #118, Silver Spring, MD Harminder S. Sethi, M.D.

52767

Registrar

31. Dete filed (Month, Dey, Year) AUG 0 9 2000 32 Registrer's Signeture

	formant G790 12/				Cert	tificate of	Dealli			Reg. No.		26845
ysician	Decedant's Name (First,			-					2. Date of De Month	Day	Year	3. Time of Death
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by Funeral	1 Never Married 2∑ 3 Widowed 4 Div	•	Armed Forces 1 Yes 2 X if Yes, Give Yeer or Dates:	?		/es Decedent of I Yes, specify Cub ☐ Yes 2(7)No			Rican, etc.)	Bie	ck, White, y: Whit	etc.
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5	Hugh Wallace		Time Driet		10h Mallina	g Address (Stree	Lur		ycoff	or City or Town	State 7in	Code)
	John F. Wall											ton, Md.20
	20a. Method of Disposition	(400)	7011	20b. Pla		sition (Neme of setory or other pla	-	1011	Date	20c. Location		
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	21. Signature of Scheral Se			net.	22	tan Cres	ess of Fecil	ity				VA.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year **Physician** LEE S. WEINBERG 8 4 2000 3:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Director 577-07-5104 12-24-06 WASHINGTON, Usual Residence of Decedent Manyland 10a. Stete 10b. County 10c. City. Town or Location r than "natural", or floring 23s or 28s-f show the Medical Examiner must be nothing at 10d. Inside City Limits XX Yes 2 No Directo MONTGOMERY SILVER SPRING the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2222 WASHINGTON AVE. 20901 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: WHITE p 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If from 27 is marked other than "na any injury or other treumstic event Elementery/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER NON PROFIT Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 16 Mother's Name (First Middle Maiden Surname) Be CHARLES SHOFINOS JENNIE SHACK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) DR. ARNOLD WEINBERG SON 5001 STRAIGHT STAR PLACE, COLUMBIA, MD 21044 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 8-7-00 COLUMBIA, MD 21. Signature of Funeral Service Lip 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final DYSPHAGIA & WEEKS diseese or condition resulting in deeth) Examiner Examiner 8 WEEKS EREBROVASCULAR ician and burisi-transit death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last physician the buris HYPERTENSION 68760 Physician/Medicai Due to (or es a consequence of): Box 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yas 2 No 3 Probably 4 Unknown ۵ IABETES MELLITUS Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Matural 1 Yes 2 No death. • Euneral Director: A letely filled in by the f 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical completely (Check only one) To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 05885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12

State Registrar

STEVEN 31. Dete filed (Month, Day, Year)

AUG 10

DHMH 16 Rev 6/95

LIPSON

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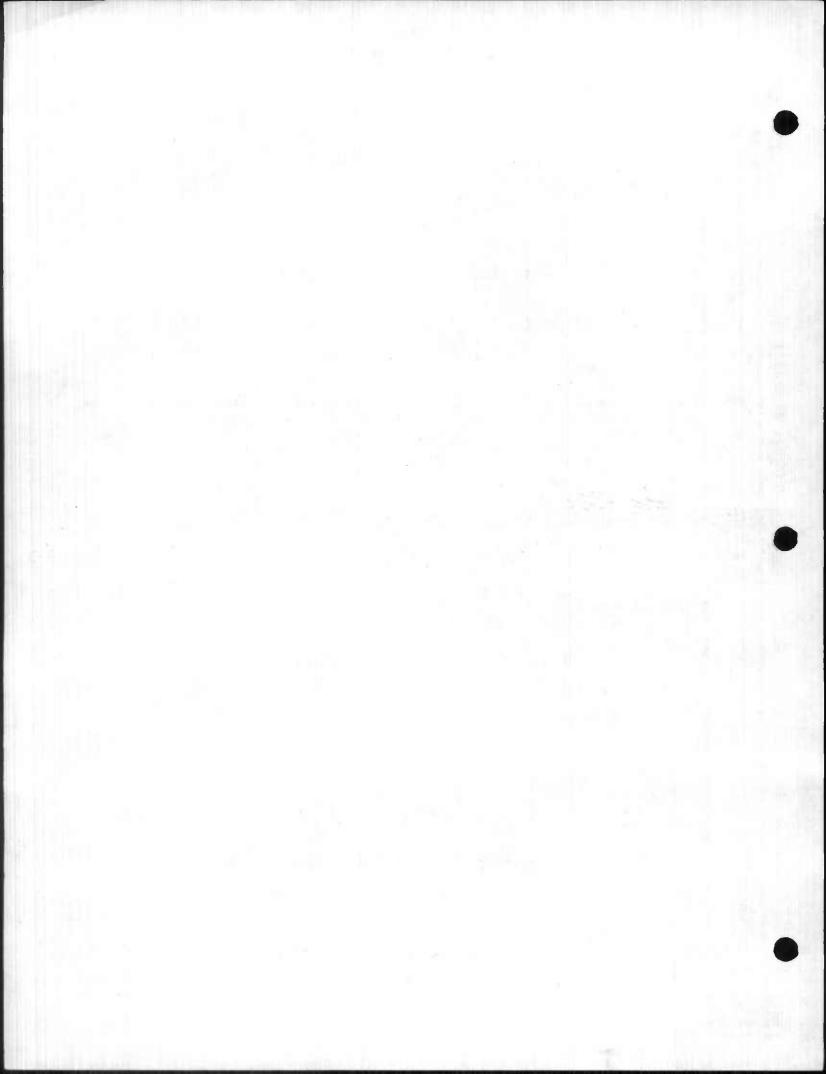
32. Registrar's Signature

Enera

MONTROSE

ROAD,

ROCKVILLE

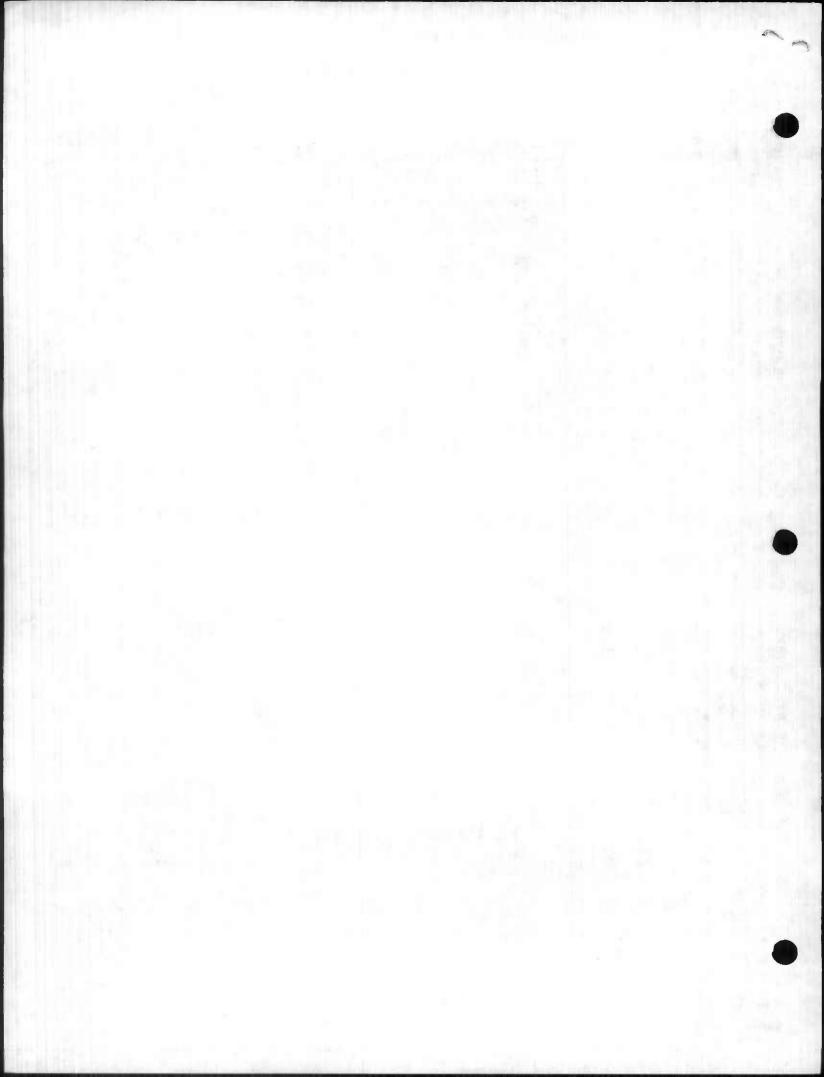


State of Maryland / Department of Health and Mental Hygiene

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26847

					Cei	rtificate	e of	Death			Reg. No.		L- 0 (2 -7 1
	_	1. Decedent's Neme (First, Middle, L.	est)		J-1-7	The Auto-				2. Dete of De Month		Year	3. Tim	e of Death
Physicia		Julius E. Whi	te							August	5. 2000		11	:45 A
/Medica Examine		4a Facility Name (If not institution, gi		imber)				4b. City, To	own, or L	ocation of Death				
LXamme	-1	Heartland of Hy	attsvil	16			T	Ivatts	2374 1 1		Princ	00 C0	0200	
· - ·			Sex	7. Age (in yrs. les	st hirthday)	If Under	1		24 Hrs.		h FIIII			
Funeral			12 M 2□ F		2 Yrs.	Months	Deys	Hours	Min.	8. Dete of Bird (Month, Da	Y. Year) 1918	Cou	ntry)	te or Forei
Director	-	240-16-5233 Usuel Residence of Decedent								reb.,	, 1910	NOTE	n ca	LOTIU
2	1	10a. Stete 10b. County	100	10c. City,	Town or Lo	cation							10d. Insid	e City Limi
tary a da	6	N/A N/A		77-	1									Yes 2 N
of the last	Directo			was	sningt	ton, I		•			10 001 1			
th with the Maryla 23s or 28s f shoutst be notified at	늄	10e. Street and Number				101. Zip					10g. Citizen of	what Cou	ritry r	
6 2 3	ē	824 Underwood S	treet, l	N.W.			012				United			
Nems Der m	Funeral	11. Meritel Status	12. Wes Dec	edent Ever in U,S. orces?	13.	Wes Decede If Yes, speci	ent of I ify Cub	Hispenic Or pan, Mexica	rigin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	14. Ra	ce - Ameri		n,
a 2 H		1 Never Merried 2 Married	1 Yes, Gi			1□ Yes 2					Specil	R B	1ack	
	by	3	Yeer or D	Detes:				Ороспу			Оросп	,. D	Lack	
72 h	Completed	15. Decedent's E			16a. Deced	dent's Usuel	Occu	pation	et al ward	ina	16b. Kind of B	usiness/ir	dustry	45
E	8	(Specify only highest gr Elementary/Secondary (0-12)	College (life.	DO NOT us	e retire	d)	St Of WOIN	uig				
E STA	6	12	- Conogo (,		Secur	ity	Guar	:d		Priva	ite		
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	o Be	Epps J. Renwick						C1	ara	Sartor				
No.	=	19e. Informent's Neme/Reletionship	(Time Print)		10h Mallir	na Address	/Stree	t and Numb	er or Pu	rel Route Numbe	er City or Town	State 7	n Code)	
9 11 1														
them 27	-	Darleen E. White 20e. Method of Disposition	e/Daught		92/6	Adelp sition (Nam	hi	Road	#203	Hyatts Dete	20c. Location			
PERO		1 Burial 2 Cremation 3 [Removel from	State	netery, crer	metory or of	her ple							e
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TE SE		21. Signature of Funerel Service Lice	gsee	1	22	. Neme end	Addr	ess of Fecil	ity					
SEES		1 /12 / 1 7	homen	and						Service,				
	-	23a Part 1 Enter the disease or con	anlinations that	caused the death	Do not ent	/400	Gec	orgia	Aver	ue, N.W	. Wash.	, D.	C. 20	
-		23e. Pert1. Enter the diseese, or con shock, or heart failure. List only	one ceuse on e	eech line.	DO HOL SHI	er the mode	o or dy	ing, such es	Scarciec	or respiretory e	1051,		Interva	Between and Deeth
hysician													0110011	ino Booth
/Medical Examiner		Immediate Ceuse (Final disease or condition	Art	erioscle	rotic	Card	iov	ascul	ar D	isease		1	year	cs
N 19 37		resulting in death)	4.	Due to (or a	as a consec	quence ot):								
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e attending physician and of for use as the burial-transit	Examine	Sequentielly list conditions.	D	Due to (or e	es e consec	quence of):								
rial-I		if eny, leeding to immediate cause. Enter Underlying												
skcii e bu	Medical	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	C	Due to (or e	s e consen	mence of).						-		-
th st	8	resulting In death) Last		200 10 (0.0		1001102 017.								
oging and	3		d									-		
attending p	Physician													
6 4 5	3	Pert II. Other algnificant conditions	contributing to d	eeth but not resulti	ing In the u	nderlying ca	ause gi	iven in Pert	1.	23b. Dld	tobacco use co	ontribute	to the car	Jee of des
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has ge 2	E										. V			.V
certificate harector, page										10	Yes 20 No	1	☐ Yes	26 No
ector o	a a	25. Was case referred to medical axaminer?	Managhab				100		e of Dea	th (Check only o	one)			
90	0	1 ☐ Yes 2 ☐ XNo	Hospitel: 1	Inpatient 2 El	R/Outpetier	nt 3 DO	A O	her: 4 XN	ursing He	ome 5 Resi	dence 6 □Ot	her (Spec	ity)	
After the funeral	Ë	27. Manner of Death 1 ☐ Naturel 5 ☐ Pending	28a. Date (Mon	of Injury 2 oth, Day Year) 2	8b. Time of	1 2	Bc. Inju	ork?		28d. Describe	how injury occu	rred		
or death. ector: Afte by the fune	at C	2 Accident investigation	n			М		Yes 2] No					
cto by th	2	3 Suicide 6 Could not l	289. Place	a of Injury - At hom	e, ferm, str	reet, factory	, offica	7-			Street and Num	ber or Ru	ral Route	Number,
after death Director: d in by the	Certification:	4 Homicide	build	ling, etc. (Specify)						City or To	wn, State)			
Funeral Funeral Itely filled		29a. Certifier 1□ Certifying P	hvelcian: To the	best of my knowle	edge death	n occurred e	at the t	ime. date a	nd place.	and due to the	cause(s) and m	anner as	stated.	
Fur Fur ately	edicai		miner: On the b	esis of examinetio										150(s)
3 7 2 6		29b. Signeture end title of certifier	Und III dil		0	290	Licen	se number			29d. Date sign	ed (Month	Day Va	ar)
T CO		250. Signisture end title of certifier	1	1	()	250.	. LICOIT	30 110111001			230. Date sign	ou (worth	, Doy, 10	ur,
4		Frence	and	uen	~	D	0018	352			August	9, 2	000	
		30. Neme end address of person who	completed caus	se of death (Item 2	3e) (Type,	Print)		- 11	3.					
		Paul A. DeVore	M.D.	4203 Que	ensbu	ry Ro	ad.	Hyat	tsvi	.11e, MI	20781			
¹ State		31. Dete filed (Month, Dey, Year)		Registrer's Signetur										
Registra	5	AUG 1 0 2		seneva	19.	200	uk	2						
ricgisti ai		MOGIU	UUU		/	1								

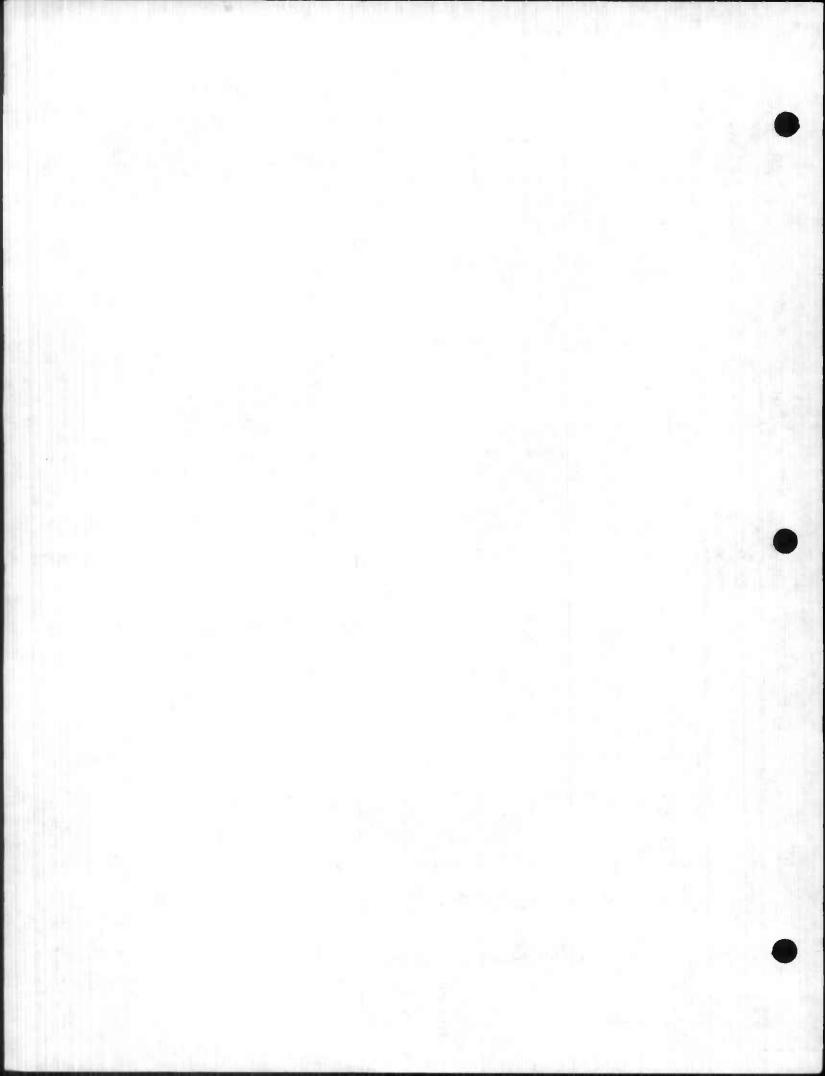


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Amend #31, see #32, 8/9/2000, BMW, Montg. Co. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Edward A . Wilson 4 2000 8:42 PM August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) **Funeral** 1 XM 2 F 84 Yrs. 8, 1916 199-09-6603 Pennsylvania Director Usuei Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County il Hygiene, other than "retural", or thems 23s or 28s-f shor vent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Silver Spring Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 USA 801 Milestone Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 X Married Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mechanical Engineer Self-employed 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental marked Fannie Hulslander John Wilson 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) . 801 Milestone Drive, Silver Spring, Maryland 20904 Lola Mae Wilson / Wife utment of Health vitant: If itsen: 27 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stale ä 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Parklawn Memorial Park 08/09/00 Rockville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Hines-Rinaldi Funeral Home 21. Signeture of Funeral Service Licenses 11800 New Hampshire Avenue alam Silver Spring, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical minutes Examiner Due to (or es a consequence of) Examiner minutes The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest and the burial-trar value replacement and aortoplasty daye signed by the attending physician d be detached for use as the buria Box 68760 **Physician/Medical** Due to (or as a consequence of) Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24e. Wes an eutopsy performed? Be Completed has 1 Yes 2 No certificate al or Attending Physicien: The safer death.

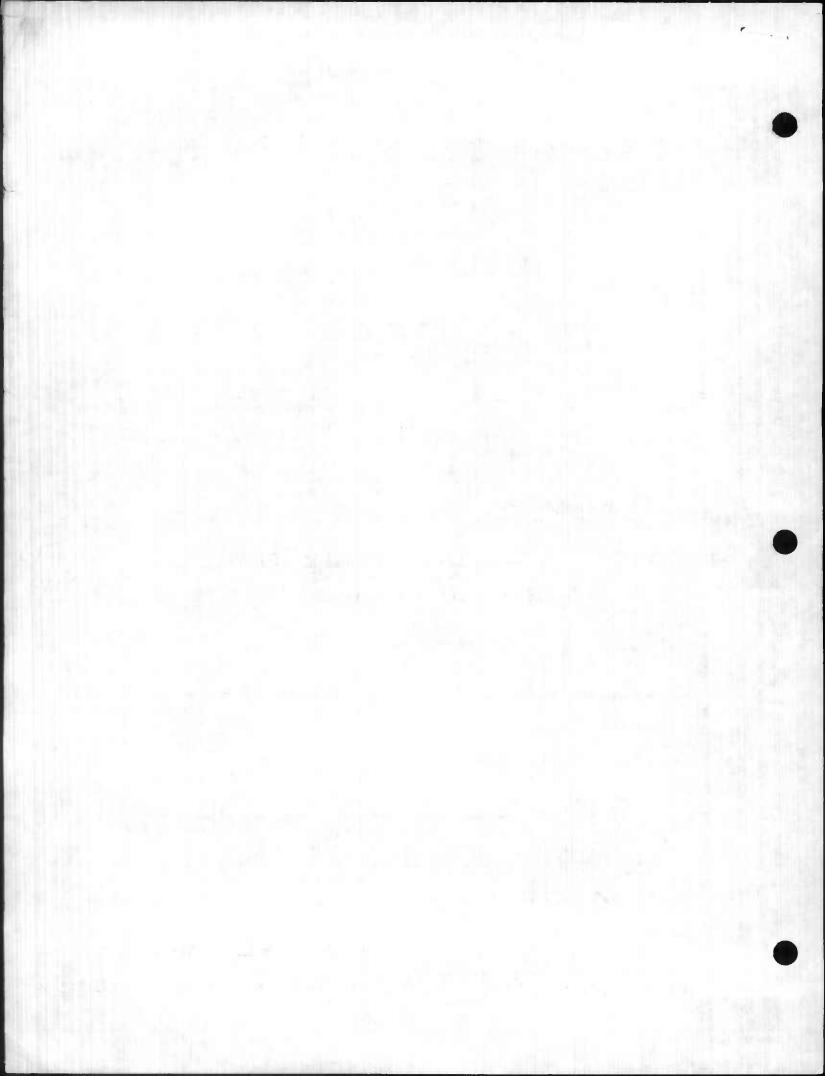
I Director: After this certificate ed in by the funeral director, pa 25. Wes cese referred to medical 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA 27. Menner of Death Time of 28d. Describe how injury occurred tnjury et Work? 5 Pending investigation Injun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier 30 Neme and address of person who completed cause of death (ttem 23a) (Type, Print) 1610 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 0 9 2000 AUG Registrar



State of Maryland / Department of Health and Mental Hygiene 00 26849

					(Certifica	ate of i	Death	Re	g. No.		
			1. Decedent's Neme (First, Middle, Last	1)					2. Dete of Deat			3. Tima of Death
	Physicia	an	EVA	100 D					AUG-UST		Yeer	10:20 am
	/Medic		4a Facility Neme (If not institution, give				- 9	th City Town or	Location of Deeth	4c. County of		
7	Examin	er			sc n'+	-11			imore	N/		
			Good Samar			oc 1	der 1 Yeer	If Under 24 Hrs				(Ct-4 Ei
	Funeral		5. Sociel Security Number 6. Se	711 -075	yrs. lest birth	month is.		Hours Min	(Month Day	Year)	Count	ace (Stete or Foreign
	Director		3000 14360	² X ¹ 87		13.			June 2, 1	1913	Virg	inia
	2 .		Usuel Residence of Decedent 10a. Stete 10b. County	10	c. City, Town	or Location					111	Od. Inside City Limits
	ahou at			100							10	1 X Yes 2 No
	1 7 8	cto	MD N/A		Balti	more						1 M 162 5 □ 140
	9 9 9	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of W	hat Count	lry?
	ith with the Maryla 23a or 28a-f sho uat be notified at	0.00	4414 St. Thomas	Ave			21206		100	United	l Sta	tes
	8 89	Funeral	11. Meritel Stetus	12. Was Decedent Ever	In U,S.	13. Wes De	cedent of H	Ispanic Origin? (S	Specify Yes or No-		- America	
0	or its	2	1 Never Merried 2 Married	Armed Forces?				en, Mexican, Puer	to Hican, etc.)		, White, e	
050	1,1	by	3 XWidowed 4 ☐ Divorced	If Yea, Give "Year or Detes:		1 ☐ Yes	2 No	Specify:		Specify:	Whi	te
9	72 hours natural.	Pe	15. Decedent's Edu	ucation	16a. C	Decedent's U	suel Occup	ation		16b. Kind of Bus	iness/Ind	ustry
7	O Service	Completed	(Specify only highest grad		- (Give kind of life. DO NO	work done	during most of wo	rking			
212	No.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Во	ttling				Calvert	Dis	tiller
0	DE TE		17. Father's Neme (First, Middle, Last)				,	18. Mother's Ne	me (First, Middle, I	Aaiden Sumame	3)	
Maryland 21215-0020	o de de de de de de de de de de de de de	o Be	John Walters					Margaro	t Beckle	nimor		
2	d Ma	To	19a. Informent's Neme/Relationship (Ti	in a Drine)	10h	Atailian Adde	ann /Ctrant		urel Route Number		State Zin	Code
Ma	2 G 1 B											
	135		Merle D. Wood /					as Ave		ore, MD		
more	of the second		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ F		Ob. Plece of I cemetery	, cremetory	or other plea	ce)	Control of the contro	20c. Location - (iny or 10	MI, State
E	THE ST		4 □ Donetion 25 □ Other (Specify))	Chesaper	ake Cre	matory,	Inc	8/5/00	Beltsvi	lle,	MD
alt	S Santa		21. Signeture of Funerel Service Licens	100	1-1			ss of Fecility	1			
0	88188		1 James (11	Lite					ohrmann,		MD C	11000
		-	23a Pert 1 Enter the disease or comp	lications that raused the	death Dong	ot enter the n	Gree	n Pastur	es Dr.,	LOWSON,	MD Z	.1286 Approximate
93			23a. Pert1. Enter the diseese, or comp shock, or heart failure. List only o	ne cause on each line.								Interval Between Onset and Deeth
) !	hysician /Medical		Immediate Cause (Finel	6	1 .		0) 1		+			Fine to
	Examiner		disease or condition resulting in death)	a. Caro	2101	res	KICIT	ory ar	res)			5 minutes
		_		Due	to (or as a co	onsequence	of):				17	BDAYS
	D tis	Examiner		Gang	reno	SUS	130	Wels				ט טאעט כ
	and tran	кап	Sequentially list conditions, if any, leading to immediate	Due	to (or as a co	onsequence	of):					
0,	de exit		cause. Enter Underlying Ceuse (Disease or Injury								i	
68760,	death certricate be executed a attending physician and od for use as the burial-transit	edical	thet initieted eventa resulting in death) Last	Due	to (or es e co	onsequence (of):					
9	eath cermical attending pt	Mec										
Box	endi r use	and N		d								
<u>. </u>	de att	100	Part II. Other significant conditions con	ntributing to death but no	at resulting in	the underlyin	a cause giv	en in Pert I.	23b. Dld to	bacco usa con	tributa to	the cause of death?
0	ch th	Physician/				,			1 D Y	2 2 No	3 □ Prot	ably 4 Unknown
0	med b	by P										,
Vital Records,	v requires that been signed I should be det	Q P							248. Wes a	n eutopsv		re autopsy findings
Ö	per ned	Completed							perlori	ned?	cor	nilable prior to inpletion of cause
še.	S 5 C	dE							14.00	,	010	death?
	P S S	3							1 🗆 Yo	s 2 No	1 🗆	Yes 2 No
===	Physician: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only on	e)		
of	dire dire	2	1 Yes 2 No	Hospital: 1 Inpatient	2□ER/Outp	patient 3	DOA Oth	er: 4 Nursing	Home 5 ☐ Reside	nce 6 Othe	r (Specify	1)
			27. Menner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Ti	me of jury	28c. Injur Wor	y at k?	28d. Describe he	w injury occurre	bd	
Division	Arrending in death. actor: After by the fune	Certification:	2 Accident investigation	(1		М		Yes 2□No				
5	after death Birector: /	Hic	3 Suicide 6 Could not be determined	28e. Place of Injury	At home, ferr	m, street, fec	tory, office		28f. Location (S)		er or Rura	Route Number,
ā .	D in a	en	4 Homicide	building, etc. (S	peciry)				City or Town	i, Steley		
	Hospital 24 hours Funeral riely filled		29e. Certifier 1/V Certifying Phy	raician: To the best of my	v knowledge.	deeth occurr	ed at the tir	ne, date end plec	e, and due to the c	use(s) and mar	nner as st	ated.
	Fur etely	edical		iner: On the basis of examiner and menner steted.								
	to the hospital of Atte within 24 hours after de To the Funeral Directo completely filled in by the	M	29b. Signature and title of certifier	1			29c. Licens	e number	2	9d. Dete signed	(Month,	Day, Year)
			10 mm	W 1 1)		00	554	0	_		1,2000
	6		Jougan D.	14.6	/.			00.1	_	10003	, 1 0	, , , , , , ,
			30. Neme end address of person who co	ompleted cause of deeth	(Item 23a) (T	Type, Print)	100	T4 . (1-) -	. 0.741	2.14	l.	1021239
			BIYUN NOLAN			2740	NAKI	סרן אאו	THILLS	Daltim	ore, r	11/21/2/39
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registrar's S	Signeture	4	100 11					



State of Maryland / Department of Health and Mental Hygiene 00 26850

					Certificat	e of	Death			Reg. No.			
		1. Decedent's Neme (First, Middle, La	ist)						2. Dete of Dec		W	3. Time of Dea	ith
	Physician	Daniel Konan	Yao						Month August	Day 1, 2	OOO	9:40 a	m
	/Medical Examiner	4a Facility Name (If not institution, give					4b. City, To		cation of Deeth		of Death		
	Enditimici	Holy Cross Hospi	tal				Silve	r Sp	ring	Montg	omery	7	
	Funeral			(In yrs. last birt		1 Year	If Under		8. Date of Birt (Month, De			lace (State or For	reign
	Director	103-78-8813 Usuat Residence of Decedent	MXM 2□F	44	Yrs. Months	Days	Hours	Min.	Aug. 31	, 1955	Adjar	ne, Abij	an
	Manual Ma	10a. State 10b. County		10c. City, Town	or Location	77					1	0d. Inside City Li	mits
	or 28a-f st be noutled Director	Maryland Prince	George's	Riverd	lale 10f. Zi	Code				10g. Citizen of V	What Coun	NYYes 2 □	No
	death with the Maryland ms 23s or 28s-f show f must be notified. neral Director	6217 Kennedy Str			20	737				Africa,	Ivo	ry Coast	
020	be fled within 72 hours after death with the Marylan be fled with the Marylan of other than *natural*, or flems 23s or 23s-1 show avent, the Medical Exercitive must be notified as a Second of the Medical Exercitive must be notified as Be Completed by Funeral Director	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Dates:		13. Wes Dece ti Yes, spe	cify Cubi	Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)				
	S ho			16a.	Decedent's Usu	et Occup	ation			16b. Kind of Bu			
200-51313	should be filed within 72 ho Mental Hygiens. marked other than "naturi matic avant, the Madeal. To Be Completed	(Specify only highest grave Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	+)	(Give kind of we life. DO NOT L	ork done se retire	during mos d)	t of workir	ng	Barnsid	la Dia	ner	
3 :	Hygie ther the Co	12 17. Father's Neme (First, Middle, Last)		COOK		18. Mothe	ar's Na <i>me</i>	(First Middle	Maiden Surnan		ilei	
	ges 1 and 2 should it of Health and Men if item 27 is marked or other traumatic 1	Bernard Kouadio 19a. Informant's Name/Relationship		106	Mailing Address	/Street			o Kone	er, City or Town,	State 7in	Code)	
3	N a m a											0000)	
	emit. Peges 1 and lepartment of Health Aportant: if item 27 in ny injury or other tr ince.	Cecile E. Yao - W	ite		7 Kener Disposition (Na		creet	, K1	Date	20c. Location -	20737 City or To	own State	
5	Peges nert of I	1 X Buriel 2 ☐ Cremation 3 D		cemeter	y, cremetory or	other ple	ce)	1					
	amit. Peges ppartment of pportant: If it ny injury or o	4 Donation 5 Other (Special	-	Willia	amsville				/27/00	Abidja	in, A	frica	
	any inje	21. Signature of Funeral Service Lice	nsee	tout		s Fu	ineral	LHom	e, P.A.	attsvill	o M	D 20781	
e/		23a. Pert1. Enter the disease, or com- shock, or heert failure. List only	polications that caused	the death. Do n							Le, III	Approximate Interval Between	
	physician and state of the burist-transit street burist-transit st	Immediate Cause (Finat disease or condition resulting in death)	4.	penic Se	-								
	and Hrar	Sequentially tist conditions, if any, leading to immediate		Due to (or es a d	consequence of)								
50.00	earn centricate be executed attending physician and for use as the burial-transit clan/Medical Examir	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. Pneumo:	nia							i		
	di the	that initiated events resulting in deeth) Last		Due to (or as e c	onsequence of)						i		
	Z 55 Z		d. Lymphom	na							i		
	deam of attended for us												
	0 0 0	Part II. Other algnificant conditions of	contributing to death bu	it not resulting in	the underlying	ceuse giv	ven in Pert I	1.				the causa of debably 4 🖔 Unk	
5	b od											NO. I Service Co.	-
	hould hould								24a. Was perfo	an eutopsy rmed?	av co	ere autopsy findir ailable prior to imptetion of causi deeth?	
	ne has b page 2 s								10	Yes 210 No	- 14	Yes 2 No	
1	certificate rector, pag	25. Was case referred to medical					26 Dia-	of Death					
	rhystolan: Inalia in this certificate ha ral director, page ral director. Page Com:	examiner?	Hospitel:	nt 2 ER/Ou	Instinct all a	Oth	her.		Check only o	dence 6 Oth	or /Consider	(v)	
	2 2 2	27. Manner of Death				28c. tnju				now Injury occur		y)	
	or Attending Prince of the Court of the Cour	1 X Natural 5 Pending investigation		Year) tr	njury M		rk? Yes 2□						
	or An after d in by in by	3 Suicide 6 Could not be determined		iry - At home, fe :. (Specify)	rm, street, factor	y, office			281. Location (S City or Tox	Street end Numb vn, Stete)	per or Rure	al Route Number,	
	Funer Tely fill		nyatcian: To the best of miner: On the basis of and manner state	examination and									
1	Med	29b. Signature and title of certifier	19 00		29	c. Licens	se number			29d. Date signe			
	(1)	Kathleen	U mesha	ine	^	1016	5073			Avz	1 20	rus	
N	(0)	30. Neme and address of person who	completed cause of de	eath (Item 23a) (Type, Print)								
		Kathleen McShane,	M.D. 122	1 Merca	ntile L	ane,	Larg	o, MI	2077	4			
		31 Date filed (Month Day Year)	32 Registra										

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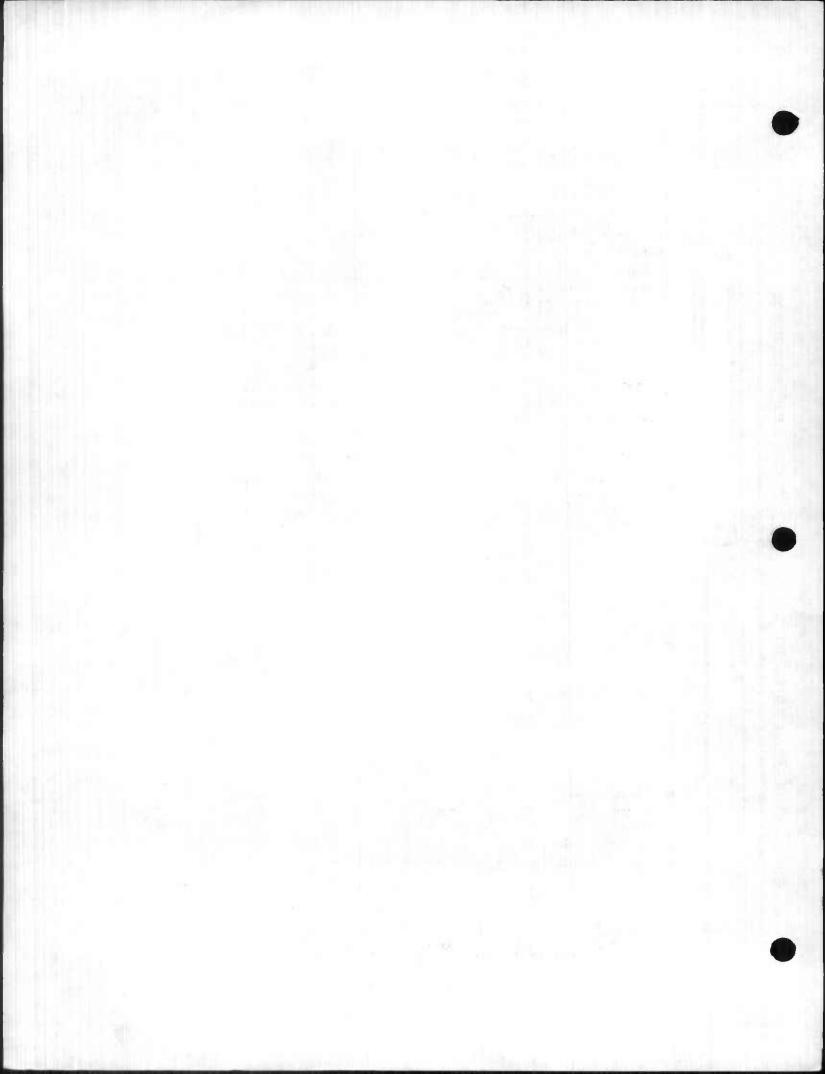
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State of Maryland / Department of Health and Mental Hygiene 0 2685 |

Certificate of Death Reg. No.

			C	ertifica	ite of	Death		Reg. No.	bas 1	0001	
	1. Decedent's Nama (First, Middle, La.	st)					2. Data of De	ath	V	3. Tima of De	ath
Physician /Medical	Esther Irene Zi	mmerman					August	16, 200	OC	8:35	pm
Examiner	4a Facility Nama (If not institution, give	a street and number)				4b. City, Town,	or Location of Deat	4c. County	of Death		
	Laurel Regional H	ospital				Laure	l	Princ	ce Geo	orge's	
ral tor	5. Social Security Number 6. S 202–14–3599	ex 7. Age (In)	rs. last birthd Yrs	Month	er 1 Yaa s Days			th Year) 2, 1924	9. Birthpla Country Penr		oreign
	Usual Residence of Decedent		O: 7								
ctor	Md. Prince G		City. Town o Laurel	Location					100	ld. Inside City L 1 ☐ Yas 2 [
al Director	10e. Street and Number 9004 Eastbourne L	ane		10f. 2	2070	08		U.S.A.		ry?	
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Datas:	1 U,S. 1			Hispanic Origin? ban, Mexican, Pu Specify:	(Specify Yes or No erto Rican, atc.)	14. Raci Bled Specify	e - America ck, Whita, et Whi	tc.	
pete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	ecedent's Us	ual Occu	upation	vorkina	16b. Kind of Bu	usinass/Indu	ustry	
Completed	Elementery/Secondary (0-12)	College (1-4or 5+) 2 years		a. <i>Do Not</i> nemake		a during most of a ed)		Own Ho	ome		
Be C	17. Father's Name (First, Middle, Last)			THE LE		18. Mother's N	lama (First, Middle	Maiden Sumam	1a)		
ToB	Andrew Szabo					Esther	Cooke				
-	19a. tnforment's Neme/Retationship (Type, Print)	19b. M	eiling Addre	ss (Stree		Rural Routa Numb	er, City or Town,	Stata, Zip (Code)	
	Charles Zimmerman	/ spouse	900	04 Eas	stbou	rne Lan	e Laurel	, Md. 2	20708		
	20a. Mathod of Disposition 1 Burial 2 Cermation 3 4 Donation 5 Other (Specify	Removal from Stata	o. Place of Di cematary,	crematory of	r othar pl		Aug 18	20c. Location -			
9000	21. Signature of Funeral Service Licen			Donalo	and Add	Funeral	Home, P.	Α.		20707	
ian cal	23a. Part1. Enter the disease, or come shock, or heart failura. List only limmediata Causa (Final diseasa or condition rasulting in death)	olications thet caused tha done cause on each lina. Myocardia.				ring, such as card	liac or respiratory a	rrast,	; 1	Approximate Interval Batwee Onset and Dea	ith
dical Examiner		Dua to	o (or as a con	sequence o	f):						
al Examiner	Sequentially tist conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury	Dua to	o (or as a con	sequence o	1):						
Medical	that initiated events resulting in death) Last	Dua to	(or as a con	sequence of	n):						
<u>e</u>	Part It. Other significant conditions or	natification to death but not	anultina in the			ives in Bod t	22h Did	tobacco use co	ntelbute to	the sauce of d	to oth 3
/ Physician/	Part II. Other significant conditions of	ontributing to death but not	rasuling in th	e undenying	causa g	IVen in Pert I.		Yea 2 No			
Completed by				<u> </u>				an autopsy ormed?	avai	re autopsy findi ilable prior to apletion of caus leath?	
Comp							10	Yas 2 No	10	Yas 2 No	
Be C	25. Was casa referred to medical					26. Place of E	Death (Check only				
To E	axaminar? 1 ☐ Yas 2 ☒ No	Hospitat: 1 ☐ Inpatiant	XER/Outpa	itient 3	OOA O	ther: 4 Nursing	Homa 5 ☐ Resi	dence 6 □Oth	ar (Specify))	
on:	27. Mannar of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Deta of Injury (Month, Day Year	28b. Tim	a of	28c. Inj W		1	how injury occur			
Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of tnjury - A building, atc. (Spe	t homa, farm,	street, facto	ory, office		28f. Location (City or To	Street and Numb wn, Stata)	er or Rurat	Routa Number	r,
edical		valcian: To the best of my liner: On the basis of exam and mannar stated.									
M	29b. Signatura and titla disertifier			2	9c. Licer	nse number		29d. Data signe	d (Month, D	ay. Year)	
	30. Nama and stidress of person who o	wh the	MD 1201 (Time	ne Print	D544	188		August	17, 2	2000	
		317 Cherry L			Mas	cyland	20707				
Curt	Bennett So, MD 8 31. Data filed (Month, Day, Year)	32, Registrar's Si		aurer/	ricil	.y.and	20101				
State	1 0 200	1 /2 Allers	19	do	a W	1					



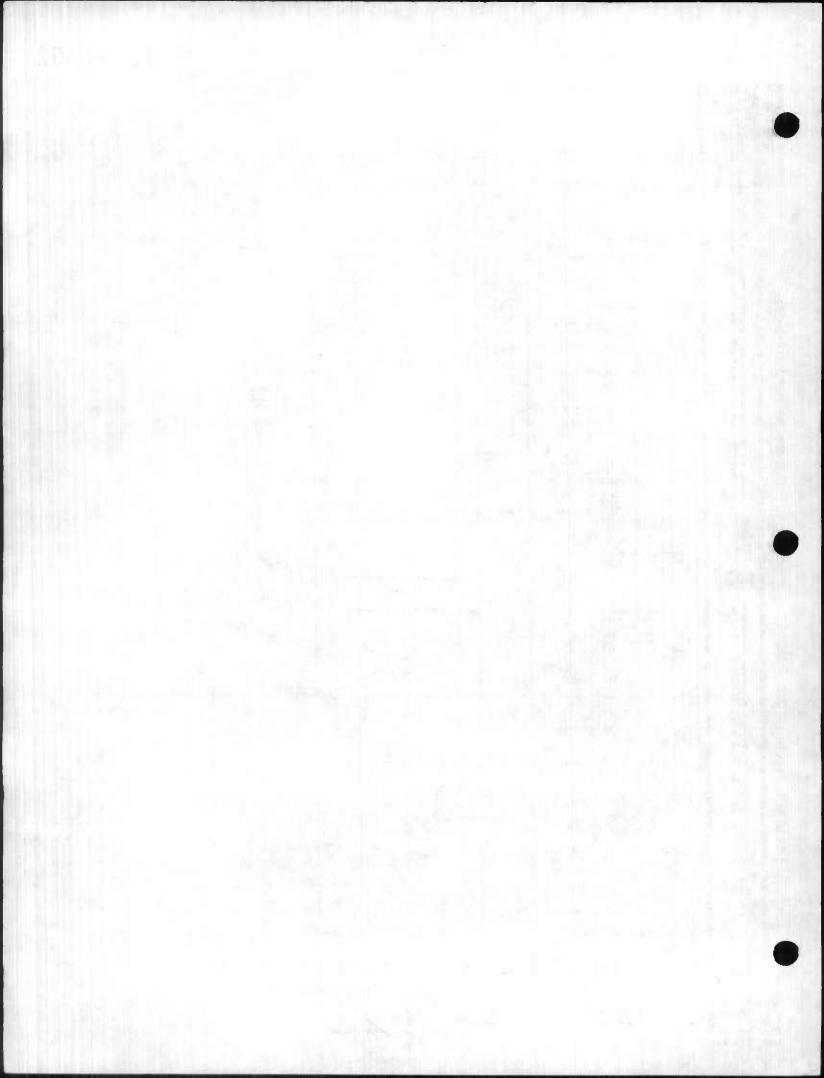
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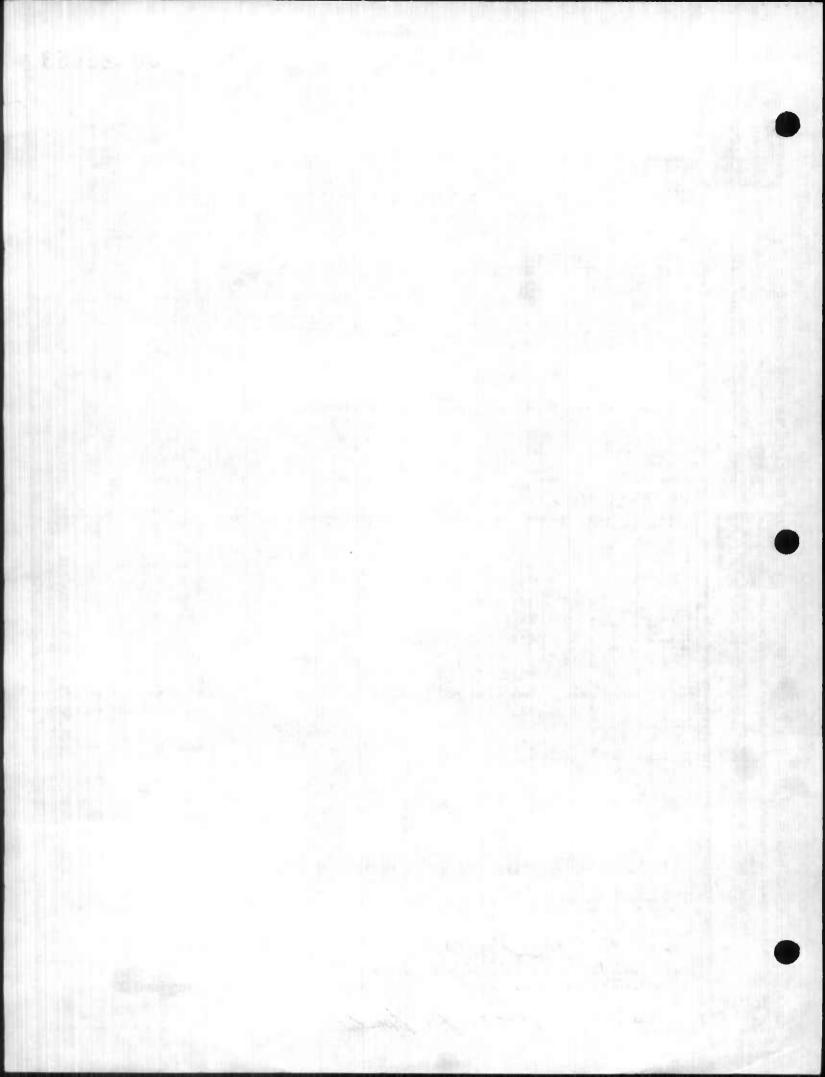
32. Registrar's Signatura



avid Terre	nce Betz ITEMS: #23 PART	State of Maryla I, 27, 28A	nd / Depa	intment of the of	lealth and N Death	Mental Hy	giene () (26853
Dhuaisia	Decedent's Neme (First, Middle, Last	1)		SERVICE SERVICE		2. Date of De Month		3. Time of Death
Physicia /Medica	David Tellence					August	20, 20	00 5:16 P.M.
Examine	4a Facility Nema (If not institution, give 111 Sea Breeze Dr				4b. City, Town, or L Ocean C.			of Death ester
Funeral	5. Sociel Security Number 6. Se		s. last birthdey)	If Undar 1 Yaar	If Under 24 Hrs.	8. Dete of Birt (Month, Da		9. Birthplace (State or Foreign Country)
Funeral Director	213-82-0275	M 2□F 41	Yrs.	Months Deys	Hours Min.	10-9-19		Maryland
2 .	Usual Residence of Decedent 10a. Steta 10b. County	100.0	City, Town or Loc	cation				10d. fnside City Limits
f sho	MD Hor	cester	, , , , , , , , , , , , , , , , , , ,		cean Cit	У		1 ☐ Yas 2 ☑ No
20 after death with the Marylar or farms 23e or 28e+f show smither, must be notified at	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
(f) will		rive		2184	12		USA	
tame tame	111 Sea Breeze D 11. Meritel Status 1 Never Merried 2 Married	12. Was Decedent Ever in Armed Forces?	U,S. 13. V	Vas Decedent of h Yas, specify Cub	Hispanic Origin? (Sp en, Mexican, Puarto	pecify Yas or No Rican, etc.)		- Amarican Indian, k, White, atc.
7. or at	1 ☑ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detas:	1	☐ Yes 2⊠ No	Specify:		Specify:	White
5-002 72 hours matural, fical Eus		ucetion	16a. Deced	ent's Usuet Occup	pation	ina	16b. Kind of Bu	einass/Industry
21215-0020 d within 72 hours at piene. r than 'natural', or the Medical Exam	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12) 12th	Collega (1-4or 5+)	life. C	ONOT use retire	during most of world)	wig	Mackey's	
					18. Mother's Nem	e (First Middle		
and be covered to	Thomas Betz					Carpinsk		
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	19a. Informent's Name/Ralationship (7	Type, Print) Father	19b. Meilin	g Address (Street	end Number or Ru			State, Zip Code)
E 20 FM - No	Thomas Betz				oad, Ocea			
Pages 1 hant of H net. If her rry or oth	20a. Method of Disposition 1 Burial 2 Cremation 3			sition (Neme of natory or other ple	ce)	Dete /24/200		City or Town, State Ore, Maryland
Baltimore, semil. Pages 1 s Separtment of Hea myortant: If them my Injury or othe sides.	4 □ Donetion 5 □ Other (Specify 21. Signeture of Funerat Service License	1	t. Stani					
D Per Department	Maria 91.2	Janneiso	26	3 South Co	nkling Stre	et, Balti	more, Mar	Jr.Funeral Home yland 21224
No.	23a. Pert1. Entar the disaesa, or corpor shock, or heart feilure. List only of	blicetions that caused the decona causa on each line.	ath. Do not ente	ar tha moda ot dyl	ng, such es cardiac	or raspiretory e	rrast,	Approximata Interval Between Onset and Deeth
Physician /Medical	Immediate Cause (Final	METHADO	NE AND) ETHAN	OL INTO	/TCATT	ואר	
Examiner	diseese or condition resulting in death)	8.	(or as e conseq		OL 111107	TCALL	714	
D =		b						
BOX 68760, eath certificate be executed attending physicien and for use as the bunkel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to	(or es a conseq	uence of):	F1 /-		43 -6	
8760, cate be ex physicien a	that initiated events resulting in death) Last	C. Dua to	(or as a consequ	uence of):				
oertific ding passes as		d			lar.			
death cert e attendin ed for use	Pert It. Other significant conditions co	potributing to death but not re	sulting in the ur	deriving cause di	ven in Pert I	23b. Did	tobacco usa con	tributs to the causs of death?
Cords, P.O. Box requires that the death cert been signed by the attendin should be detached for use	Pert II. Other significant conditions co						Yes 2□No	3 Probably Astonknown
d Signer						24a Waa	an eutopsy	24b. Were autopsy findings
Cords requires been sign should be							rmed?	svallable prior to completion of cause of death?
i Record The lew require ste has been si page 2 should						180	res 2 No	1 Ves 2□ No
- 40	25. Wes case referred to medical				26. Place of Dea			70
	examinar? XXYes 2 No	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpetien	t 3 DOA	har: 4 Nursing H	ome 5 Resi	dence 6X00the	ar (Specify) at scene
DIVISION O To the Hospital or Attanding Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	27. Menner of Death 1 Neturel 2 Accident 3 Sulcide 4 Homicida 5 Pending investigetion 6 Could not be datarmined	For Month Day Year)	E OUT d	P 28c. Inju	ryat rk?]Yas 2.∏vNo	JNKN	now injury occurr OWN	ed
Division or Attending after deeth. Obrector: Afte d in by the fune	2 Accident investigation 3 Sulcide 6 Could not be datamined	28e. Plece of Injury - At	home, ferm, stre		X	28f. Location (Straet end Nurab	Y or Sure Route Nursee ZE
Disagraphic of in Color	Homicida datamined	building, etc. (Spec	MOBILE	HOME		DD 0	ATM WITH THE R A. P. L.	ITY, MARYLAND
Hoept 4 hou Funer tely fill	29a. Cartifiar 1 Certifying Phy (Check only 2 Medical Exam	valcism: To the best of my kn iner: On the basis of examin						
To the Hospital within 24 hours a To the Funeral completely filled	29b. Signeture and title of certifier	and menner steted.		29c. Licens	sa number		29d. Dete signed	1 (Month, Dey, Year)
F 3 F 8	1 1//	~ M.I.),		O.C.M.E.		August	21, 2000
	30. Neme end address of person who d		em 23e) (Type, I	Print)			100	
	MARYG. RI			Penn Str	reet, Balt	cimore,	Maryland	21201
Stat Registra	VIII. 0 4-2000	32. Registrar's Sign		low VI				

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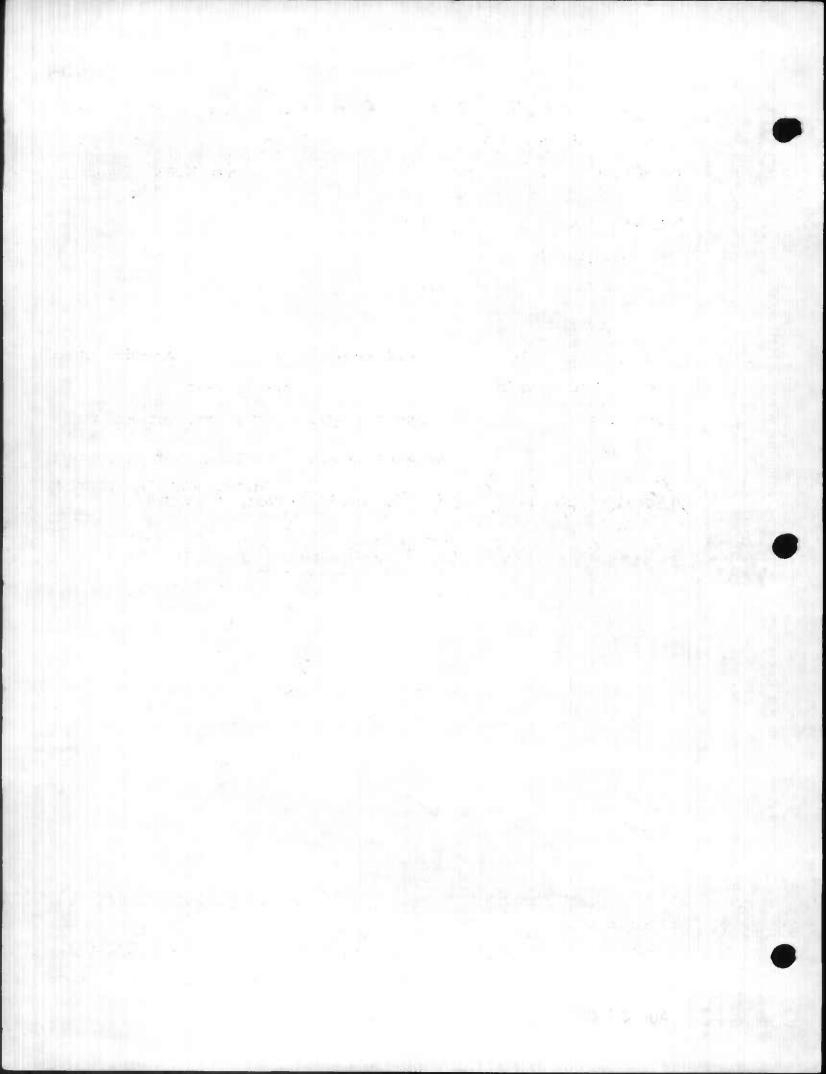
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last 2. Date of Death Yaar **Physician** 2:02 20,2000 MUS 4b. City, Town, or Location of Death /Medical 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) January 23, 1932 Birthplaca (Stata or Foreign Country) **Funeral** 1 XXM 2□ F Min Days Hours Months 68 404-36-6368 Director Kentucky Usual Residence of Deceden the Manyland 10a. Stata 10d. Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location 1.□ Yes 2□ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with "natural", or items 23s or 5301 Purlington Way 21212 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 1 Des 2 □ No Korea If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2)(No Specify: White Specify: by 3 Widowed 4 Divorced er than "nature, Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. President Executive Recruiting marked other 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be named the heart of Health and Mentel David Wallace Baird Jr Eleanor Newman 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health (Important: If Ilem 27 Is any injury or other fra Ruth D Baird Wife 5301 Purlington Way Baltimore, Maryland 21212 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 (C) Cremation 3 ☐ Removal from State 4 ☐ Donalion 5 ☐ Other (Specify) Greenmount Cemetery 8/23/00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc war 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner end I-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to Immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con physician er Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): attending p Se signed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown à 24b. Were autopsy findings evallable prior to been si Completed 24a. Was an autopsy performed? completion of cause of death? is certificate hes director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Wes case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dale of Injury (Month, Day Year) funerel 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Netural 5 Pending 1 Yes 2 No investigation efter death. Director: A 2 Accident 28f. Location (Streat and Number or Rural Route Number, City or Town, Stele) 6 ☐ Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours efter Funeral Dire letely filled in b To the H. within 24 l. To the Fun. edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print) IVIVE Registrar's Signature State AUG 2 4 2000 Registrar



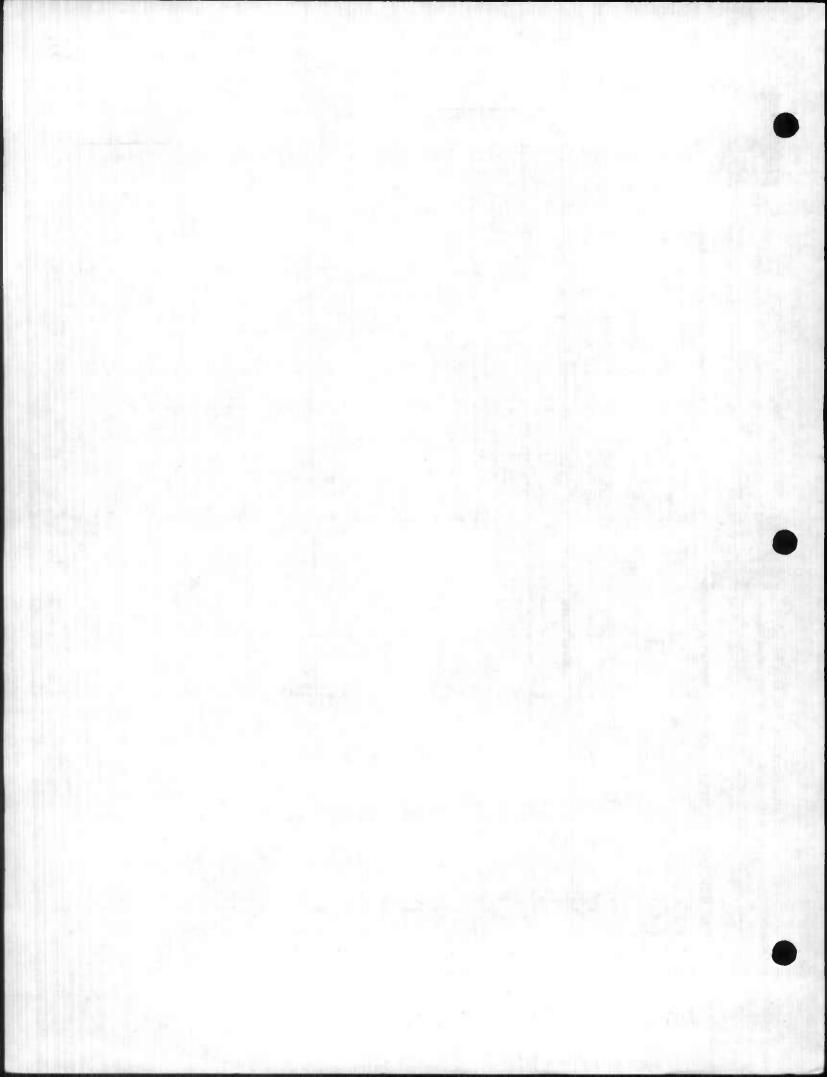
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 4c per fh G786 8/24/00 yf 1. Decedent's Nama (First, Middle, Last) CHARLES EDWARD BUTTON 2. Date of Death 3. Time of Death **Physician** 3:20 PM ton tugust 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Balti enter Daltimore Hopkins Johns tenatric. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 15 M 2□ F 86 213-09-8905 Director June 21, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limita 10a. Stata 10b. County r than "natural", or items 23s or 28s-f show the Medical Exerciper must be notified at 1 No Yes 2 No Maryland N/A Baltimore City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5523 Sagra Road 21239 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11 Marital Status 1 Nas 2 No If Yaa, Give Year or Dates: 1 Nevar Married 2 Married 8 Baltimore, Maryland 21215-0020 White illed within 72 hours e l Hygiene. other then "natural", o Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Parts Manager Automotive permit. Peges 1 and 2 should be filed Department of Heelth and Mental Hyg Important: If them 27 is marked other any injury or other traumatic avent, 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Stockett Button, Sr. Bertha E. Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Annette B. Sanders (Niece) 205 Devon Court, Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 8/19/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rwson Karten O Mitchell-Wiedefeld Funeral Home, Inc. Plantin D. Lawson
6500 York Road, Baltimore, Maryland 21212
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 and 100 arrest.

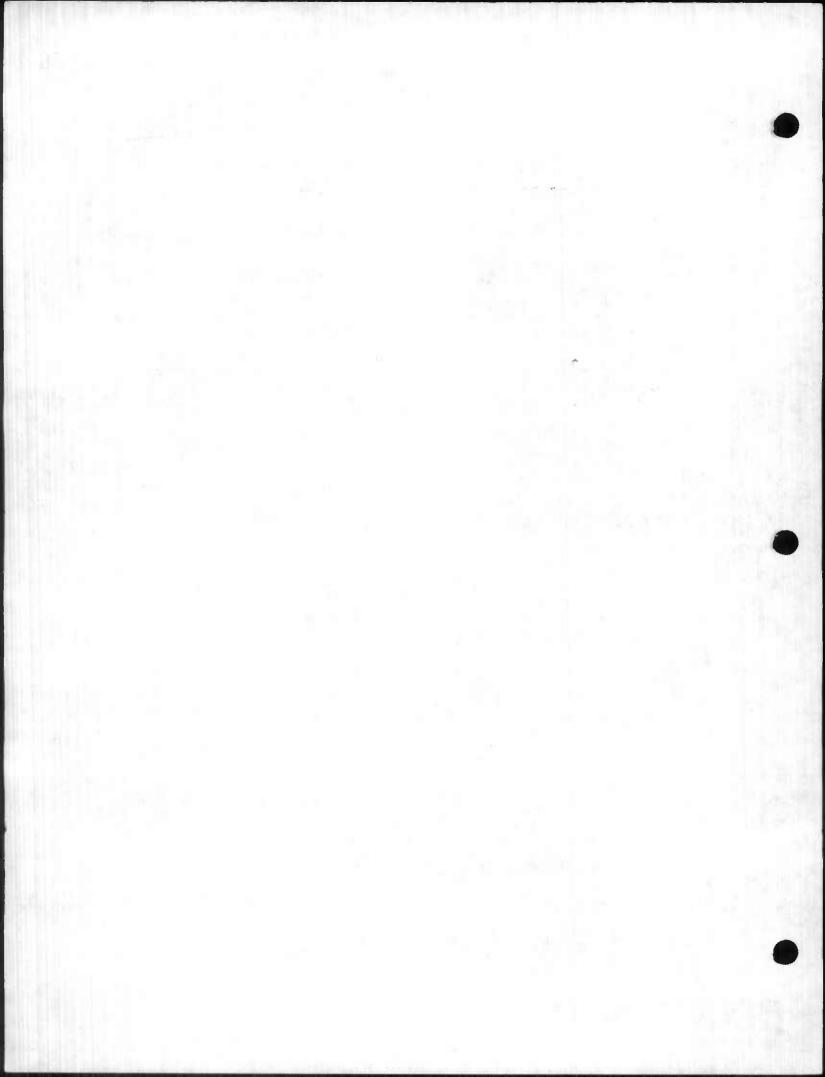
Approximately 100 and 100 arrest. Approximate Interval Between Onsat and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): attending physician for use as the buris 68760 Physiclan/Medical Dua to (or as a consequence of) Box P.O. P Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached the 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by Division of Vital Records. py 24a. Was an autopsy performed? 24b. Were autopsy findings fibrillation Completed svailable prior to complation of cause of death? 2 1 No 1 Yea 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Panding investigation Attanding 1 Natural or Attanding after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signatura and min of certifier D0056056 20/2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwen Olden guist Baltimore, Hopkins Bayview Cir MM 31. Date filed (Month, Day, Year) 32. Registrar's Signatura AUG 2 4 2000 Registrar DHMH 16 Rev 6/95

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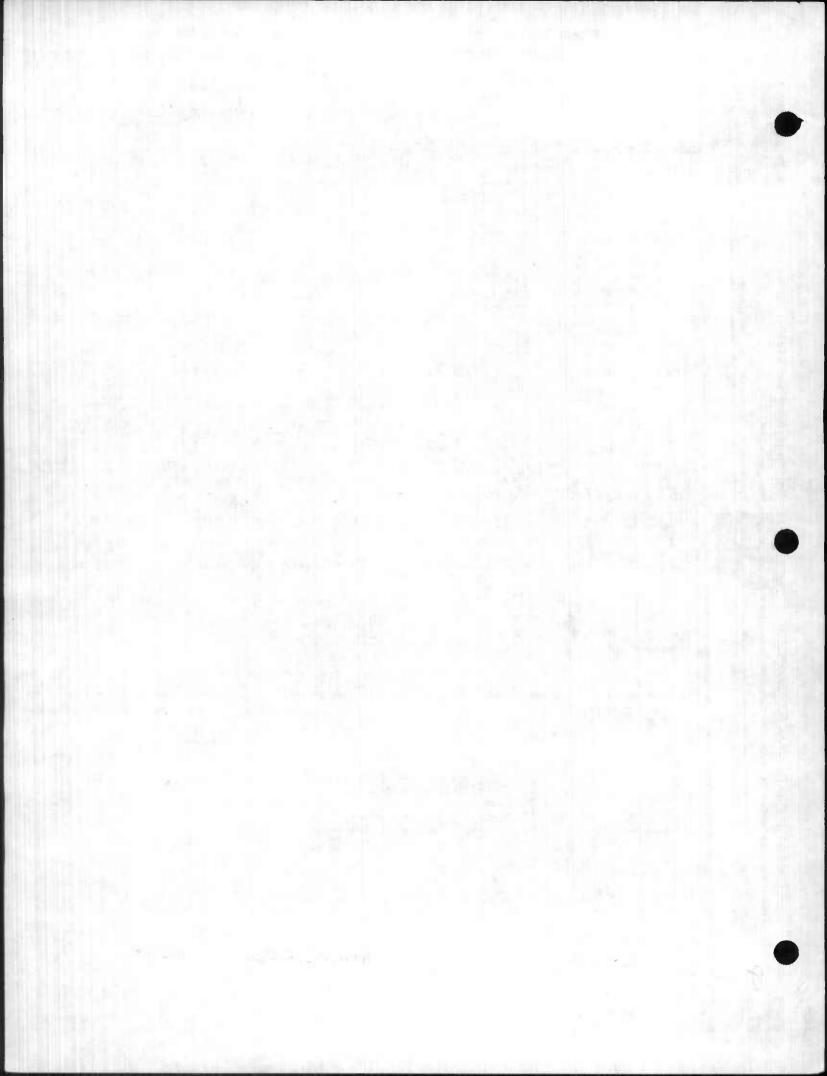


Amended Item	#23a perPHYG786 8/24/2000		nd / Department of Certificate			ene 01	0 26	856
2001	1. Decedent's Neme (First, Middle, Last)				2. Date of Death)		ma of Death
Physician	I I I K II	1 FE	BARNES	5	August	Day 15 20	Year /0:0	00 AM
/Medica Examine	An Provide Atoms Mined in Alberton when	street and number)		4b. City, Town, or f	ocation of Death	4c. County o		
	Sinai Hospital			Baltimore			ore city	
Funeral Director	001000110	7. Age (In yrs	Ast pirthday) If Under 1 Months C	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day DEC, 16	Year) 1921	9. Birthplace (S Country) UARTH C	AROLINA
N R as	Usual Residence of Decedent 10a. Stete 10b. County	10c. G	ity, Town or Location				10d. Insi	ide City Limits
/ L,	MARYLAND N/	A	BAL	TIMORE	CITY		VES	Yes 2□No
Mary with the Ma	10e. Street and Number		10f. Zip Co			g. Citizen of W		
outh v	7411 MAIN	E HVENU	IS 13 Was Deceden	2/20	-		- American India	en
Sold liber of the control of the con	11. Marital Status 1 Never Married 2 Merried	Armed Forces?		t of Hispanic Origin? (S Cuban, Mexicen, Puert	o Rican, etc.)		c, White, etc.	
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2.6	No Specify:		Specify:	BLACI	2
72 T 72 D	15. Decedent's Edu (Specify only highest grade Elementery/Secondary (0-12)	cetion a completed)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use in	done during most of wor		6b. Kind of Bus	siness/Industry	
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Maryland d 2 shout be fit th and Mental Hy T is marked oth traumatic event	19a. Informant'a Neme/Relationship (Ty	· · · · · ·	19b. Malling Address (S		- 10	City or Town,	State, Zip Code)	
- CEN 2	PAULINE D. WILLIA		2536 W. Place of Disposition (Name	LANVALE		72TING	City or Town, Ste	1.21216
Baltimore Sentil Pages 1s Separant of He my injury or other	20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ R	emoval from State	completely cramatory or other	ar niacel				
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dit.	23a. Pert 1. Enter the disease, or complishock, of heart failure. List only or	cations that caused the dea	th. Do not enter the mode of	N. F-U.LTO			Appro	ximate
Physician	shock, of heart failure. List only or	re cause on each line.						al Between and Death
/Medical	Immediate Cause (Finel disease or condition	liver	failure					
Examiner	resulting in death)		or es e consequence of):				71	
P # 5		AORTIC S	TENOSIS					
60, be executed ician and burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of):					
766 Sicio	Cause (Disease or Injury that initiated events	Due to (or as a consequence of):					
688	= resulting in death) act	500.10 (01 40 4 00/10000/100 01/.					
Box 68 auth certifica attending ph for use as th								
O e dead the at the at the	Part II. Other significant conditions con	tributing to death but not re-	sulting In the underlying ceu	se given in Part I.	23b. Did tol	sacco uaa con	tribute to the ca	
P. P. Carlot that the delay delay	Aurtic Stenosis	5			1 🗆 Ye	8 2 No	3 Probably	Unknown
d Sign					24a. Was an	autopsy	24b. Were auto	opsy findings
w requires to been si					perform	ed?	completio of death?	prior to on of ceuse
Re lev age 2	5				1 ☐ Ye	s 2X No	1 ☐ Yes	
f Vital Ryysicion: The Is contificate he director, page	25. Was case referred to medical			26. Place of De	ath (Check only one	3)		
of V hysicl this ce	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing H	lome 5 Reside	nce 6 Othe	er (Specify)	
On O Office of the Office of t		28a. Date of Injury (Month, Day Year)		. Injury at Work?	28d. Describe ho	w injury occurre	ed	
Vision Attending r death. ector: Afte	2 Accident investigation 3 Sulcide 6 Could not be	Office of lains. Ass	M	1 Yes 2 No	28f. Location (Str	reat and Numb	er or Rural Route	Number
Division (Tall or Attending P Tall all Director: Affert led in by the funer	4 Homicide determined	building, etc. (Speci	nome, farm, street, factory, o	onice	City or Town	, State)	or or marar modite	, , , , , , , , , , , , , , , , , , , ,
Division To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Physical Examination (Check only one)	ner: On the basis of examin	owledge, death occurred at attention and/or investigation, in	the time, dete end place my opinion, death occu	, and due to the ce irred at the time, de	use(s) and ma- ite and place, a	nner es stated. and due to the ca	ause(s)
o the or the omple	29b. Signature and title of certifier	and manner steted.	29c. L	icense number	29	d. Date signed	1 (Month, Day, Y	ear)
F 3 F 8		roces, De)	RESCOO	h	oust 15	7 m	
	30. Name and address of person who co		m 23a) (Type, Print)	100000	100	ן כן וכטף		
	AMY TON - DUCH	. 4 .	SINAI HOSPITA	4 2461 W	BELVEDE	REAVE,	BALTO. HE	0.21215
State	31. Date filed (Month, Day, Year)	32. Registrer's Sign						Ts III



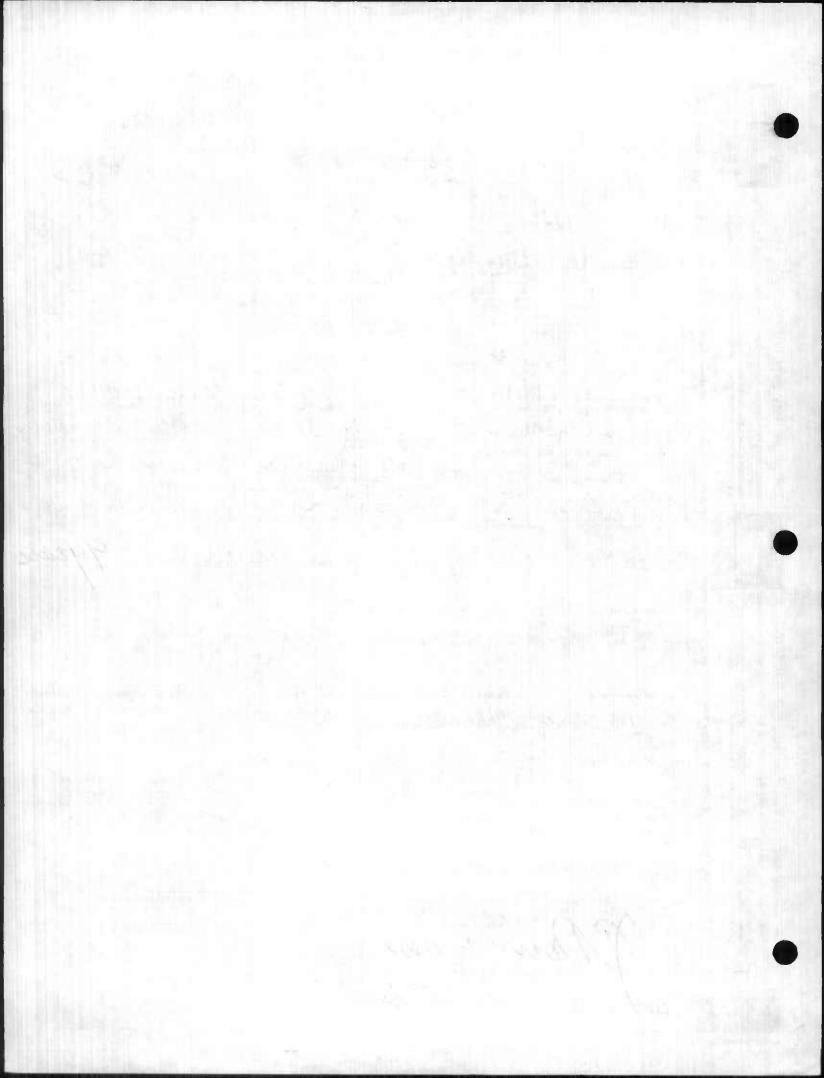
State of Maryland / Department of Health and Mental Hygiene 00 25057

halaian					Certifi	cate of	Death		Reg. No.	0 200	
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xaminer		Fecility Name (If not institution	give street and number	er) /	1.1.	,	4b. City, Town, or	Location Deat	h 4c. County	of Death	F
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eral	5.	Social Security Number			asi billioay /	Under 1 Year onths Days			th iv. Year)	9. Birthplace (State Country) MD .	or Fore
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	-	sual Residence of Decedent									011
		0a. State 10b. County		Maria .	y, Town or Location	п				10d. Inside	
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by Fu		1 Never Married 2 Marri 3 Widowed 4 Divorced		No		res 2 No		to riteall, etc./		BLACK	
Pe		15. Decedent	s Education		16a. Decedent's	s Usual Occu	petion		16b. Kind of Bu	usiness/Industry	
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E		Elementery/Secondary (0-12)	College (1-4c	or 5+)	LABO	RER			ING		
		7. Father's Name (First, Middle, I	.ast)				18. Mother's Na	me (First, Middle	, Maiden Sumam	10)	
To Be		JOHN W. BROWN					EVA K	TITV			
F		9a. Informant's Name/Relationsh	In (Type Print)		19h Mailing Ad	Hrass /Stree	t and Number or R		er City or Town	State Zip Code)	
		EVA BROWN (MOTH									6
	-	0a. Method of Disposition	EK)	20h P	Plece of Disposition		IIE AVE.	DALITI		City or Town, State	0
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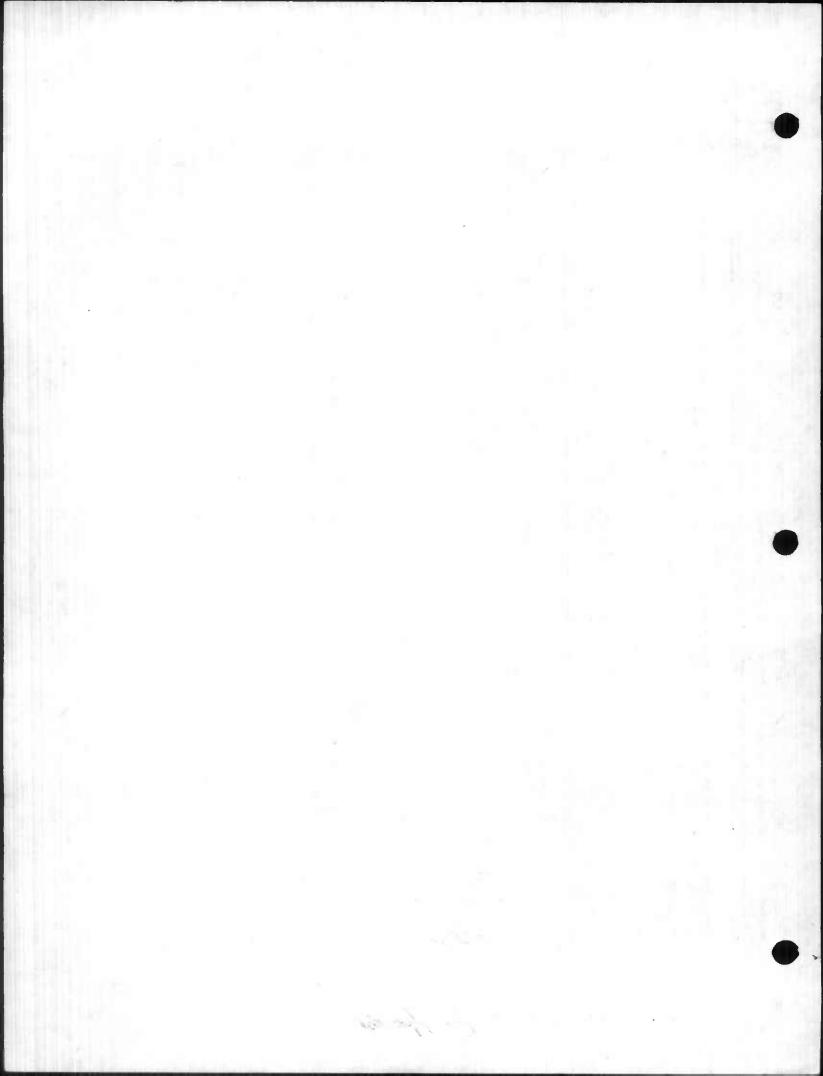
State of Maryland / Department of Health and Mental Hygiene 0 26858

			Certificate of Death	,	leg. No.	20030
	Physiciar /Medica	ı	1. Decedents Name (First, Middle, Last) COUMAN Last Name (If not institution, give street and number) 4b. Cay, Ipwn, or I	2. Date of Dea Month Location of Death	th 20, 2000 4c. County of De	3. Time of Death 7. Of Am eth
	Examine Funeral Director		6. Sey, 175. Social Security Number 6. Sey, 175. Age (In yrs. last birthday) If Under 1 Yeer Hunder 24 Hrs. Months Days Hours Min.	B Date of Birth Month, Day	N	A strolece (State or Foreign country)
	the Maryland 28a-f ahow notified at		10e. State 10b. County 10c. City, Town or Location Baltimare			10d. Inside City Limits 1 Seves 2 □ No
	death with the	runeral Director	10e. Street and Number 4320 Clareway Apt 2T 21213 109. Street and Number 21213 109. Street and Number 21213		10g. Citizen of What 6	Country?
0000	Sun of	2	11. Marital Stetus 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuben, Mexican, Puert It Yes, Sive Year or Dates:	o Rican, etc.)	Specify: O	
21215-0020	i within 72 iene. Then nei	Completed	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Busines	s/Industry
Maryland 2	ould be filed Mental Hygianted other setic event, m	lo Be C	17. Father's Name (First, Middle, Last) John A Coleman 18. Mother's Nam Mar	y Be	Maiden Surname)	uther
	is 1 and 2 should be filed A Health and Mental Hyg item 27 le merked other other treumetic event,	-	19a. Informant's Name/Relationship, (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date Number	r, City or Town, State Rd 20c. Location - City	Charlotte NC
Baltimore,	permit. Pages Department of Important: If it any Injury or once.		10 Burial 2 Cremation 3 Ramovel from State 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility	8-28-00 Home	Fairfield PA	County SC
		-	23a. Pafi1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on aach lina.	Sf. Scor respiratory ar	Baltmir	Approximata interval Between on set and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Actual Cauchy Moreover and the consequence of the consequen	eloof	tie	9years
0,	hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events Due to (or as a consequence of):			
0× 68760	o de	8	Cause (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): d.			
. Box	death ce e attendir d for use	200	Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I.	23b. Did 1	obacco usa contribu	ite to the cause of death?
0	ires that the death cer signed by the attendir d be detached for use	Dy Prny	Deep vein Thrombosis	10		Probably 4 Unknown
Division of Vital Records,	law requires has been sign e 2 should be	completed by Physicianne		24a. Was perlo	an autopsy rmed?	b. Wara autopsy findings available prior to completion of cause of death?
la	certificate has ector, page 2		25. Was case referred to medical 26. Place of De.	101		1 ☐ Yes 2 1 No
2	2 40 5	90 01	examiner? Hospital:	ome 5 Resid	na) lence 6 ☐Other (S	pecify)
o uois			27. Manner of Death 1 (D2 Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 2 Accidant investigation Accident Accide	28d. Describe	ow Injury occurred	
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	To the Hospital Within 24 hours To the Funeral completely filled	MICE	29a. Cartifier (Check only one) Check only one) Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place (Check only one) Check only one) Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place (Check only one)			
_	To the Comp	M	29b. Signature and title of careful 29c. Licanse number		29d. Date signed (Mo	
	Λ.		D33624		8	-24-50
	n		7505 OSLEY Drive Scille 30 Hours of Person who completed cause of death (Stem 23a) (Type, Print) 7505 OSLEY Drive Scille 30 Hours of Hours of Party Control of	MD 2	1204	
	State	a a	31. DAUG 2040-2000 Separationar's Signature Sports			

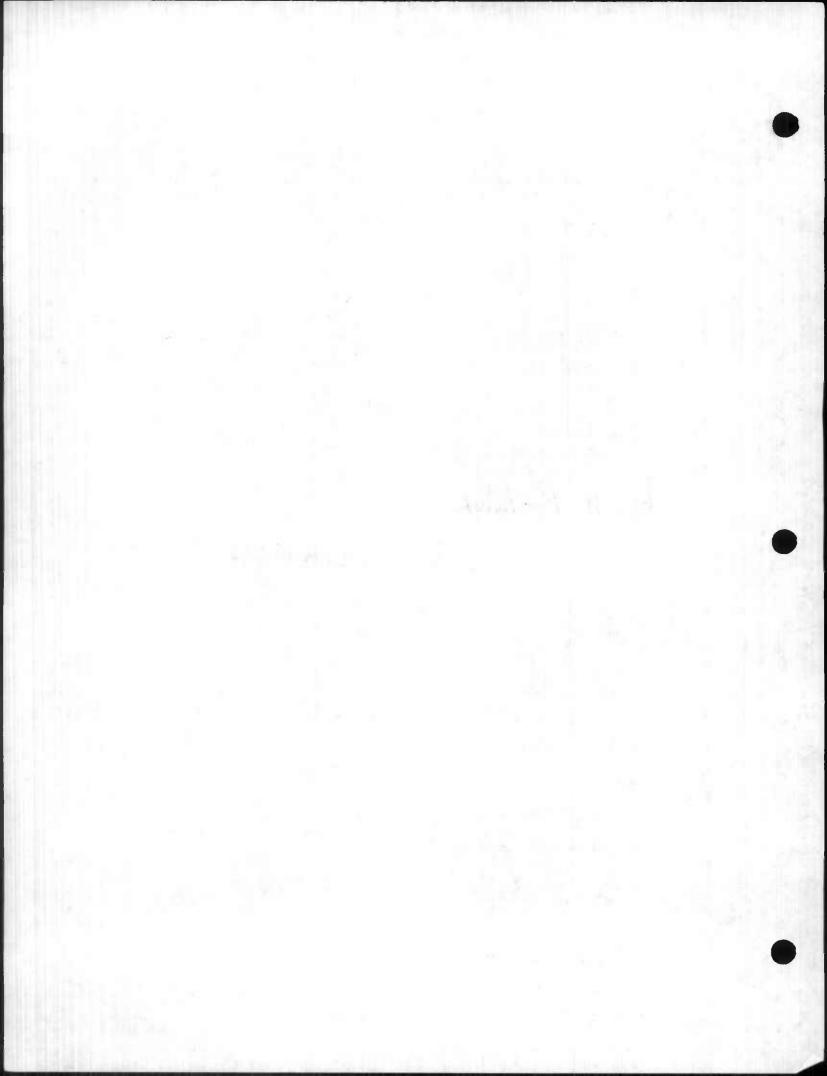


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

sician	1. Decedent's Neme (First, Middle,	Last)	1 1 1 1 1			2. Date of Deat Month	Day	3. Time of Death	
edical	Edward Way	ne Caud	111			AUG.	12, 2	2000 12:18 Pi	M
miner	4e Facility Name (If not institution,				4b. City, Town, or Lo		4c. County		
	SACRED HEAR			Milledge 4 Vace	CUMBERLA			EGANY	_
ral tor	291-36-5992	5. Sex 7. Ag	e (In yrs. last birthd 58 Yrs	Months Days		8. Date of Birth (Month, Day, 01 17	1942	Birthplaca (State or Foreign Country) KY	
	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town o	r Location				10d. Inside City Limits	
uneral Director	OH Clerm	nont	Ame1:	ia				1 ☐ Yes 2 M No	
Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	Vhat Country?	
1,000	230 Amelia Oliv	e Branch Ro	ad	45102			USA		-
by Funeral	11. Maritel Stetus 1 Never Married 2 Merrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		I3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ♣ No	Hispanic Origin? (Spo ban, Mexican, Puerlo Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. White	
per	15. Decedent's	Education	16a. De	cedent's Usual Occu	pation		16b. Kind of Bu	siness/Industry	_
ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or:	(G lift	e. DO NOT use retire	during most of work ed)	ng			
Compl	12	6		eacher			Educat	ion	
Be C	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	(First, Middle, I	Maiden Sumam	(9)	
0 8	Dowell Caudill				Carrie	Conn			
-	19a. intormant's Name/Relationshi	p (Type, Print)	19b. M	alling Address (Stree	of and Number or Run	al Route Number	, City or Town,	State, Zip Code)	
	Jennifer Caudil	1/wife	230) Amelia O	live Bran	ch Rd A	melia	Ob 45102	
	20a. Method of Disposition	-I/ WIIC	20b. Placa of Di	sposition (Name of				City or Town, State	
1	1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			crematory or other pla riah Cemet		8/17	nion To	ownship, OH	
	21. Signature of Tineral Service Li		ne. no	22. Name and Addr		0,	oniton 10	ownship, on	
	VI V			Sterling-	Achton-Sci	hwah Fun	eral Ho	ome Inc	
	23a. Part1. Enter the disoner or o shock, or heart failure. List or			736 Edmon	dson Aven	ie. Balt	o. Md.	21228	
edical Examiner	Immediate Cause (Final disease or condition resulting in death)	aCARI	Due to (or as a cor		MIA VENTRICUI	AR HYP	ERTROF	Onset and Death	
Examiner	Sequentially list conditions,	Ь	Due to (or as a con	esequence ot):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	HEALE	ED ENDOC	ARDITIS					
Medical	that Initiated events resulting in death) Last	d	Due to (or as a con	sequenca of):					
clan						1 001 0144			_
Physician/M	Part II. Other significant condition	contributing to death b	ut not resulting in th	e underlying cause g	iven in Part I.		obacco use cor 'es 2 No	ntribute to the cause of death?	
by								- /	
Completed						24a. Was a perfor		24b. Were autopsy findings available prior to completion of cause of death?	
S						1)X Y	es 2 No	1 Yes 2□ No	
Be	25. Was case referred to medical examiner?			1	26. Place of Deat	h (Check only or	10)		
0	1)X Yes 2□ No	Hospital: 1 Inpatie	ent 2X ER/Outpa	atient 3LI DOA		me 5 Resid	ence 6 Oth	er (Specify)	
1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga		ry Year) 28b. Tim Inju	ry Wo	ury at ork?] Yes 2 No	28d. Describe h			
-	Z LI MODINGIN	28e. Place of in	ury - At home, farm	, street, factory, office	9	28f. Location (S City or Tow		per or Rural Route Number,	
-	2 Accident Investigation 3 Suicide 6 Could no determin	building, el	c. (Specify)						-
Certification: T	3 Suicide 4 Homicide 6 Could no determin	building, et	of my knowledge, d					anner as stated. and due to the cause(s)	
-	3 Suicide 4 Homicide 6 Could no determin 29a. Certifier (Check only 27 Medicat E:	Physician: To the best	of my knowledge, d	r investigation, in my 29c. Licen	opinion, death occurr	red at the time, d	late and place, a	and due to the cause(s) d (Month, Day, Year)	
edical Certification: T	3 Suicide 4 Homicide 6 Could no determin 29a. Certifier (Check only one) 1 Certifying 2 Medicat Ex	Physician: To the best	of my knowledge, d	r investigation, in my 29c. Licen	opinion, death occur	red at the time, d	late and place, a	and due to the cause(s)	

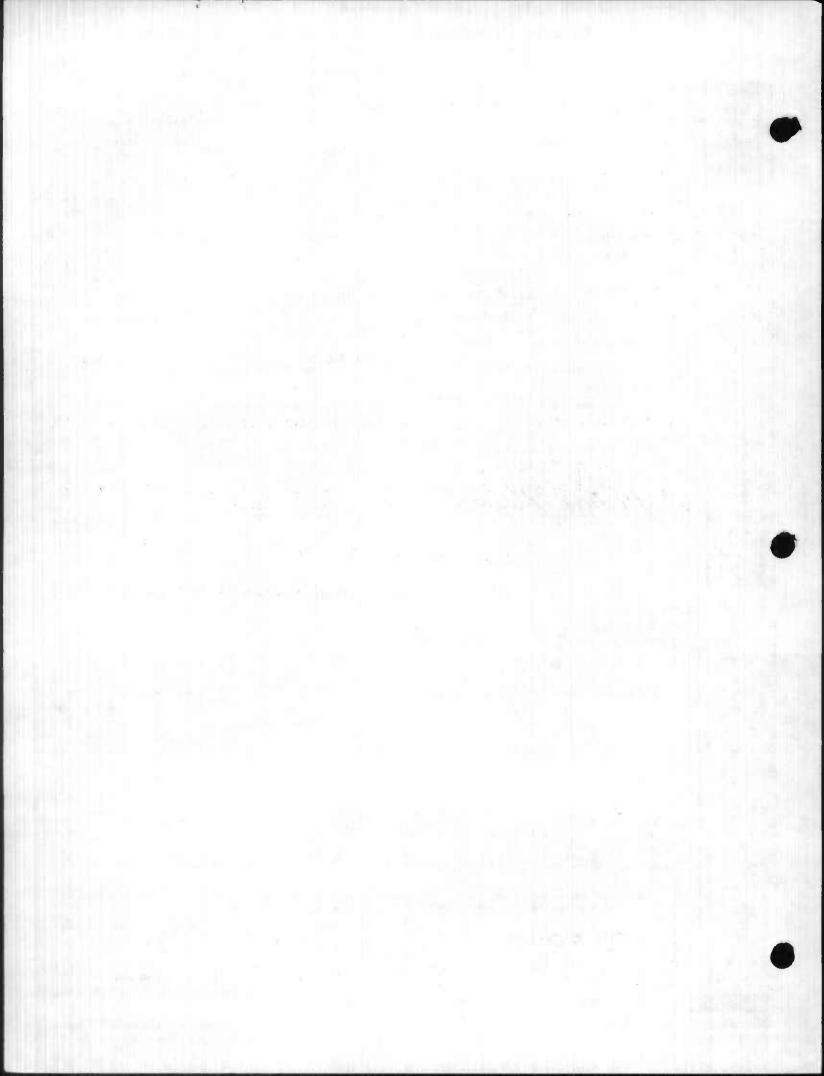


	amend	item 8 per fh G786 8/		waryian		ertificate		Death	eillai A	Reg. No.	2	6860	
	Physicia	Decedent's Name (First, Middle, Last) Andrew Raffel Colacce						Month	2. Data of Death Month Dsy August 22, 2000		3. Time of Death 2:40 am		
	/Medica Examine	4b City Town or Location of Death 4c Countries Death											
	Funeral Director	5. Social Security Number 212 20 7404	_	7. Age (In yrs. last birthday) If Undar 1 Year						B. Date of Birth (Month, Day, Year) Feb. 8,1927		Birthplaca (State or Foreign Country) Maryland	
	D Bu	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Location							1	0d. fnside City Limits	
	the Maryl 28a-f sho notified at	Maryland Harford Aberdeen 104								1 ☐ Yas 2√ No			
	offn the Ma	10e. Street and Number 10f. Zip Code 10g. Citizen of What C									itry?		
						21001				VSA Yas or No- 14. Race - American Indian,			
-	na attar de f. or itam xaminer.	11. Merital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	os? □ No				n, Mexican, Puarto Rican, etc.)			Black, White, etc. Specify: White			
			15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)				16b. Kind of Business/Industry		
3	within one.	Elementary/Secondary (0-12) College (1-4or5+) Maintenance Mechanic Hospital											
	Ind 2	17. Fsther's Name (First, Middle,	Last)					18. Mother's Name	(First, Middle	e, Maiden Surnan	10)		
	ylan ould be Mental anhaed antic ev	Raffel Colacce					Anna Marie Raffa						
	Mar 62 sh 62 sh 63 sh 7 is m traum	19a. Informant's Name/Relations Ralph Colacce						and Number or Aura l. Baltimo			State, Zip	Code)	
		20a. Method of Disposition			Place of Dis	position (Name	e of		Date	20c. Location -	City or To	wn, Stata	
	Page hent o	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S					ans Cemetery 8/24/			Garriso	n Foi	orest, Md.	
240	Baltimore, parmit Pages 1 ar Department of Hea Important: If Item any Injury or other once.	21. Signal the cuffuneral Service Licensee 22. Nama and Address of Facility Bruzdzinski Funeral Home P.A. 1407 old Eastern Avenue Essex, Md. 21221											
outee/8	Physician / Medical pe execution of the physician and mine physician and execution of the physician are as the buriel-frametic as the physician are the phys	23a. art . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as s consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
	death certificate be executed extremely physician and ad for use as the burial-transit	D	d	Due to (c	or as a cons	aquence of):							
hen	that the ded by the a	Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part t. — JHYERTENSION — CABC.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown				
An	Hecords, P le law requires that has been signed b ge 2 should be delt	Part II. Other algnificant conditions of the second of the	-ATRIAL FIBRICIATION							24s. Was an autopsy performed?		ere sutopsy findings silable prior to impletion of cause death?	
7 5	The law ate has be page 2 s	- iDAM	- iDAM								Yes 2000 1 Yes 200		
Acc	Slane Slane Startiffe tartiffe Startiff Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiff Startiffe Startiff Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiffe Startiff Startiffe Startiff	25. Was case referred to medice examiner?	11				Ott	26. Place of Deat	h (Check only	one)		H	
-	ing Phys Mer this uneral di	27. Manner of Death 1 Sea. Date of Injury 1 Netural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Netural 5 Pending 28d. Describe how injury occurred Work? 1 Type 3 The								(y)			
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral parts.	3 Suicide 6 Coufd 4 Homicide determ	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routa Number,										
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	29a. Certifier 157 Certifyi (Check only one) Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	To the within To the comple							sa number	29d. Date signed (Month, Day, Year)				
To Desigla MI)							4	2800	8/0	8/23/00			
t	6	30. Nsme and address of person	10 31	19 5	in	ea, Print)	A.	il Ha	16/	log .	710	79.	
4	State Registra	0110047	000 32. Aeg	istrar's Signa	Bulling	Span	16						



State of Maryland / Department of Health and Mental Hygiene

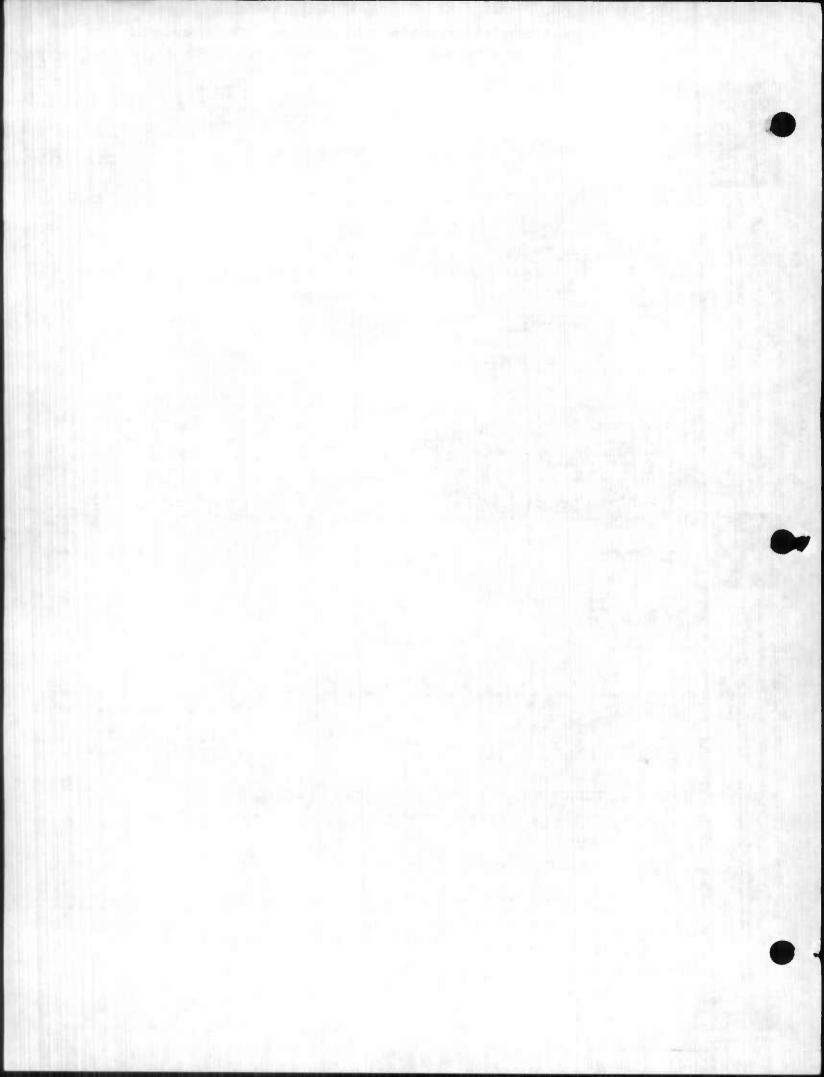
					Cei	rtificate of	Death		F	Reg. No.	1 6	0001	
	_	I. Decedent's Name (First, Middle, L	ast)	3 11 6	40.4				2. Dete of Dea		Yeer	3. Time of Death	
Physician	_	MILDRED E. DE	WEY						Month AUGUST	Dey 16, 20		2:15 AM	
/Medica Examine		a Fecility Neme (If not institution, g	ve street and nu	mber)	-14 11		4b. City, Tow	n, or Lo	cation of Death			2.13 /11	
Examinie	1	VILLA ST. MICHA	EL.				Baltin	nore			N/A		
-	5		Sex	7. Age (fn yrs.	last birthday)	If Under 1 Year				h		place (State or Foreign	
Funeral Director		214-20-7207	1□ M 2 F	95	Yrs.	Months Days	Hours	Min.	8. Dete of Birth (Month, Dey July 13	1905	Cour	place (State or Foreig Intry) D	
Director	1	Jsual Residence of Decedent							0 1 2	, 1505			
Bu .	-	IOa. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	10d. inside City Limits	
te pa	0	MD N/A			Bal	timore						1X□ Yes 2□ No	
be notified	8	I De. Street and Number				10f. Zip Code				10g. Citizen of \	What Cou	nin/?	
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iner must be notified at		4800 Seton Driv			0 140		212			14 000	USA		
tam tam	5	11. Marital Status	Armed Fo		,5. 13.	Was Decedent of I If Yes, specify Cub	an, Mexican,	Puerto	Rican, etc.)		14. Race - American Indian, Black, White, etc.		
X 25 M		1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	ve		1□ Yes 2∑ No	Specify:			Specify: white		ite	
End.		3 ☑ Widowed 4 □ Divorced	Year or D	etes:							******		
vgiene. ser than "natur it, the Medical	6.0	15. Decedent's I (Specify only highest g			(Give	dent's Usual Occu kind of work done	during most	of worki	ng	16b. Kind of B	usiness/in	dustry	
. 59 5	d.	Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)						
and a	5	12		2		secretar	у			80	vernn	nent	
a doth		17. Father's Name (First, Middle, Las	t)				18. Mother	's Name	(First, Middle,	Maiden Surname)			
urkad urkad	0	Edwin Emich					unk						
E E		19a. Informant's Name/Relationship	(Type, Print)		19b. Malli	ng Address (Stree	t and Number	r or Rure	I Route Numbe	r, City or Town,	State, Zij	Code)	
22.00		Barry Holden/nepl	new		102	S. Popp	S. Poppleton Street Baltimore, MD 21						
Hem	2	20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of matory or other pla			Date	20c. Location -		own, State	
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dun.	1	4 ☑ Donation 5 ☐ Other (Spec	-	ess of Facility									
my i	1	21. Signapore of Furneral Service Lice Ronald S	Wade, I	d 655	W. Balt	imor	e Street						
32.60	1	Monnie.	Baltimore				n. Dare	Imor	Derect				
Physician /Medical	T	23a. Part Enter the disease, or con short, or heart failure. List only	inplications that o	aused the deaf	h. Do not en	fer the mode of dy	ing, such es c	erdiac o	or respiratory ar	rest,		Approximate Interval Between	
		or House tamaro. Electors										Onset and Death	
		Immediate Cause (Final		1		m. Ace	ident	-					
aminer		diseese or condition resulting in death)	a. Cen	elso Va	- June	quence of):							
à d	5			Due to (d	quence of):	0	111						
nisit nin				, rosu	les	ause	ase	i					
physician and sthe burial-transit	Y	Sequentially list condifions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.											
		ceuse. Enter Underlying Cause (Disease or Injury	C								i		
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the at	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of the ca									o the cause of death			
ed by the detached	10								□ Yes 2□ No 3□ Probably 4 1 Unk				
be de													
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sho e	-								репо	med?	CC	vailable prior to empletion of cause death?	
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page . page	3								101	res 200 No	11	☐ Yes 2☐ No	
certificate rector, pag	2	25. Was cese referred to medical examiner?					-	of Deeth	(Check only o	ne)			
0 D	0	1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	of 3 DOA Ot	her: 4 Nur	sing Ho	me 5 Resid	dence 6 Oth	ner (Speci	fy)	
After the funeral		27. Manner of Deeth 1 ☑Natural 5 ☐ Pending	28a. Dete	of Injury	28b. Time o Injury	f 28c. Inju	ry et		28d. Describe h	now injury occur	red		
anar deam. Director: After I in by the fune		1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigation		.,, .,,,,	,,		Yes 2 N	lo					
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Within 2s routs and death. To the Funeral Director. After completely filled in by the funer. Medical Certification:	5	4 Homicide	buildi	ing, etc. (Specif	y)				City of Tor	ni, 3(6(6)			
A THIS	29e. Certifier 117 Certifying Physician: To the best of my knowledge, deeth o						ime, dete end	plece,	and due to the	cause(s) and m	anner es :	steted.	
Fundada de	29e. Certifiler (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred to the basis of exemination and/or investigation and menner stated.						opinion, death	h occurr	ed at the time,	dete end plece,	end due t	to the ceuse(s)	
M M		29b. Signature and title of certifier	0 .			29c. Licen	se number			29d. Date signe	d (Month,	Day, Year)	
F 8		D55	Lya			D	1753	7		8-	10	2000	
5 .			4				,,,,	-		0			
119	3	00. Name and address of person who		se of death (Item	n 23a) (Type,	Print)	011117	R	nual A	we B.	It-	21217	
7 0		DARSHAN. S.	SALL	M W	160	OW. M	7010		1 610	1 10	~~·		
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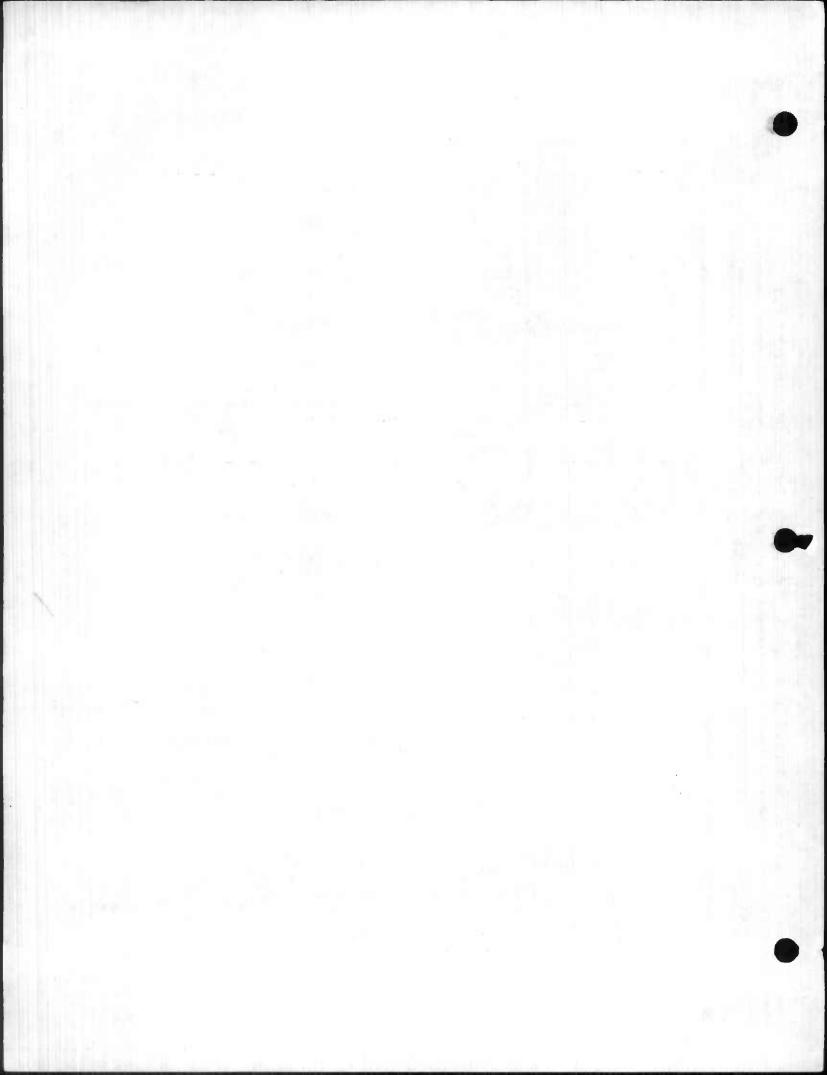
				Certifica	te of	Death		Re	eg. No.		20002
Physician /Medical	1. Decedent's Name (First, Middle Lillian Danie	1s					Ai	Dete of Deat Month	21 %	Ogo V	3. Time of Death
Examiner	4a Facility Name (If not Institution North Arundel		per)			Glen E	wn, or Location Burnie	n of Death	4c. County		ındel
neral ector	5. Social Security Number 220-09-9533	6. Sex 7.	. Age (In yrs. last bi 88	rthday) If Unde Months	Days	If Under 2 Hours	Min.	Date of Birth Month, Day, ay7, 1	Year) 912	9. Birth	placa (State or Foreigntry)
	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Tow								10d. Inside City Limits
Directo	MD Balti 10e. Street and Number	more	Lansdo		p Coda		-	1:	0g. Citizen of V	What Cou	
ral D	124 Clyde Ave	•		2	1227			U	J.S.A.		
by Funeral	11. Marital Stetus 1 Never Married 2 Merri 3 Widowed 4 Divorced	Armed Forc	™No	13. Was Deci	ecify Cuba	lispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)		k, White,	can Indian, etc. nite
Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		lor 5+)	Decedent's Usi (Give kind of w life. DO NOT	ork done	ation during most d)	of working		Garme		dustry
To Be C	17. Father's Neme (First, Middle, I	Last)					rs Nama (Fir y Marr		Maiden Suman	10)	
	19e. Informent's Name/Reletionsh			b. Mailing Addras							
	Darlene A. Sa 20a. Mathod of Disposition 1 1 Donetion 5 Other (Sp.	3 □Removel from St	20b. Place of camera	8251 Car of Disposition (No any commetory or wridge orial Pa	me of other plac		D	ate	20c. Location - Dorsey		own, State
500	21. Signature of Funeral Service t		101254	22. Name e	nd Addre		1 Home		ansdown		D. 21227
edicai Examiner	23a. Pert1. Enter the dispase, or shock, or heart teilure. List immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury		Due to (or as a):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	300 300 300			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Initarval Batween Onset and Death 5 Jams
hysiclan/Medicai	resulting in death) Last		th but not rasulting			ven in Pert I.				ntributs 1	to the cause of coats
Completed by Physician/	Dementic Cerebrovescular Accident										Vere autopsy findings vailable prior to ompletion of cause
omp							187	1 🗆 Ye	es 2 No		death?
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Sertific	3 Suicide 6 Could r 4 Homicide datermi	not be ined 28e. Placa o building	f Injury - At homa, f g, etc. (Specify)	arm, street, fecto	ry, office		281.	Location (Si City or Town	treet and Numi n, State)	ber or Rui	ral Route Number,
edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the b Examiner: On the bas and menna	is of examination as	e, death occurre nd/or investigatio	d at the time n, in my c	ma, date and opinion, deel	d placa, and th occurred e	due to tha c t the time, d	ause(s) and m lata and placa,	anner as and due	stated. to the cause(s)
W	29b. Signature and title of certifier	e. Wii	les Tet 1			4136		+	end Date signe	tz	1,2000
5 State	30. Name and address of person of Cloval E. W. 31. Date filed (Month, Day, Year)	who completed causa LCCS VI 32. Reg	of daeth (Item 23a)	(Type, Print) 301 H	ospit	al D	vive,	Gler	Bur	nie	21061
Registrar	AUG 2	A	benever	6	Soa	Mes					
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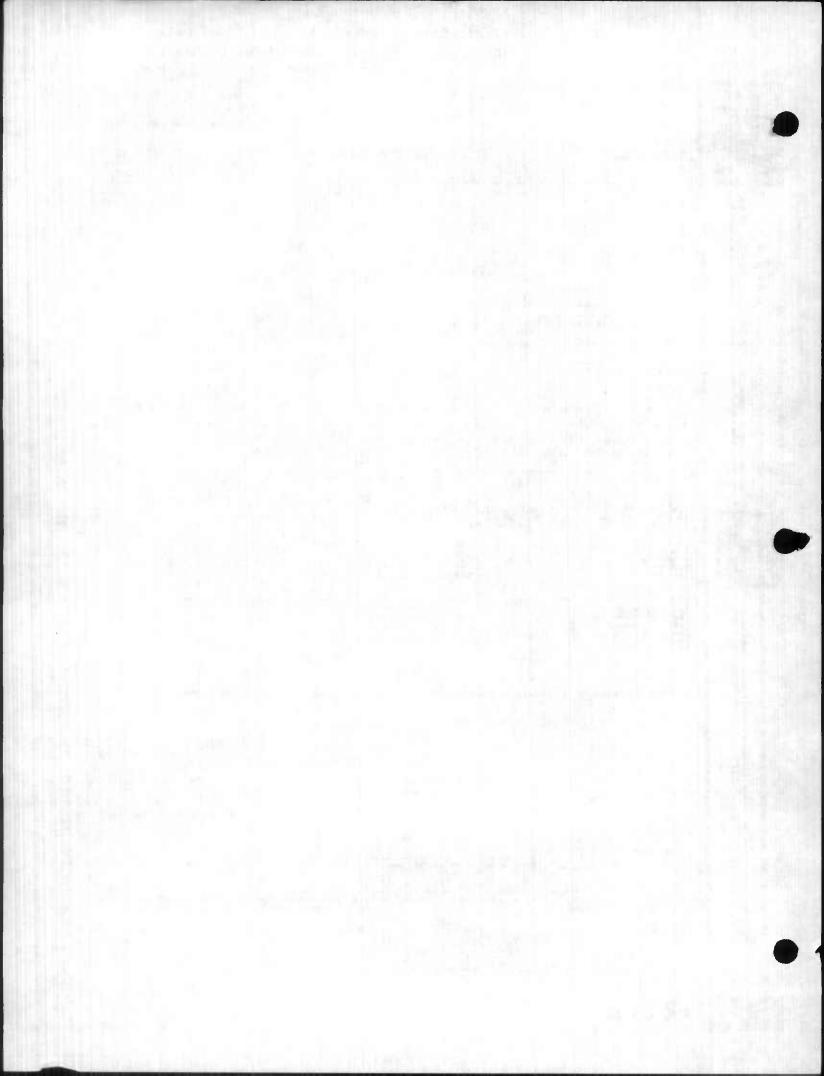
State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg. No.	2	6863	
			1. Decedent's Nama (First, Middla,						2. Data of Do		Year	3. Tima of Death	
le.	Physicia: /Medica			Juanit	a Y. 1	Durar	nt		8		000	4:50 a.m.	
	Examine		4a Facility Nama (If not institution,	The second second second				4b. City, Town, or L					
				1th and Reha			Center	Baltimor			/A		
L	Funeral Director		5. Social Security Number 213-90-2945 Usual Residence of Decedent	6. Sex 7. Age 1	32	Yrs.	Months Days		8. Data of Bi (Month, D	l-1967	9. Birthp	Md	
	Yland		10a. Stata 10b. County		10c. City, To	wn or Loc	ation				1	Od. Inside City Limits	
	Mar	50	Md N/	Α	Balti	more						1) Yas 2□No	
	after death with the Marylan or Items 23a or 28a-f show trainer must be notified at	al Director	10e. Street and Number 3520 W. Garriso	on Avenue			10f. Zip Code 21215			U S A	hat Cour	etry?	
21215-0020	5 42 3	by Funeral	11. Marital Status 1 Never Married Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yas 2 N If Yas, Giva Year or Dates:			/as Decedent of Yes, apecify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yas or N Rican, atc.)		k, Whita,		
5-0	72 hours natural;	Completed	15. Decedent's (Specify only highest		16	a. Deced	ent's Usual Occu	pation during most of work	ina	16b. Kind of Bu	siness/Inc	dustry	
121	within then.	ğ.	Elementary/Secondary (0-12)	Collega (1-4or 5	+)			during most of work of)	Private Homes				
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Maryland	2502	200	John H. Smith	1317				Flora D		s, maioen oamen	-/		
ary.	should end Men e marke	0	19a. Informant's Name/Relationshi	p (Type, Print)	15	9b. Mailin	Addrass (Stree		r Rural Routa Number, City or Town, State, Zip Code)				
	W - Z =		Flora Smith- M			2233	Wheatle	y Drive	Balt	imore,	Md 2	1207	
Baitimore,	- H and		20a. Method of Disposition		20b. Place cemai	of Dispos	ition (Nama of atory or other pla	ice)	Data	20c. Location -	City or To	wn, Stata	
E	Peges nant of int: If he ary or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe				Cemeter	1	-25-00	Baltimo	re.	Md	
ait	permit. Pege Department of Important: If eny injury or page.		21. Signature of Funeral Service Li	censee	1			ASS OF Facility H West					
m	89E 2 8		1/ Nola	Maria				abash Ave	nue E	Baltimore	. Md	21215	
			23a. Part1. Enter the disease, or c shock, or heart failura. List o	omplications that caused nly one cause on each fir	tha death. De	o not enta						Approximate Interval Batween	
	Physician				^							Onset and Death	
	∣/Medical Examiner		Immediata Cause (Final disease or condition	· FNI	CS (AC	15 F	UTOIN	Mun	E 174	FII	ENCY	
п		Immediata Cause (Final disease or condition resulting in death) a. END STAGE AUTU IMMUNE DE Due to (or as a consequence of): Due to (or as a consequence of):										12	
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P.0.	ed by the detach	METAROLIC ACIOUSIS							1	Yes 2□ No	3 Pro	bably Wonknown	
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ion	Attending P r death. ector: After I by the funer	27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 1 Year 2 No 28d. Describe how injury occurred											
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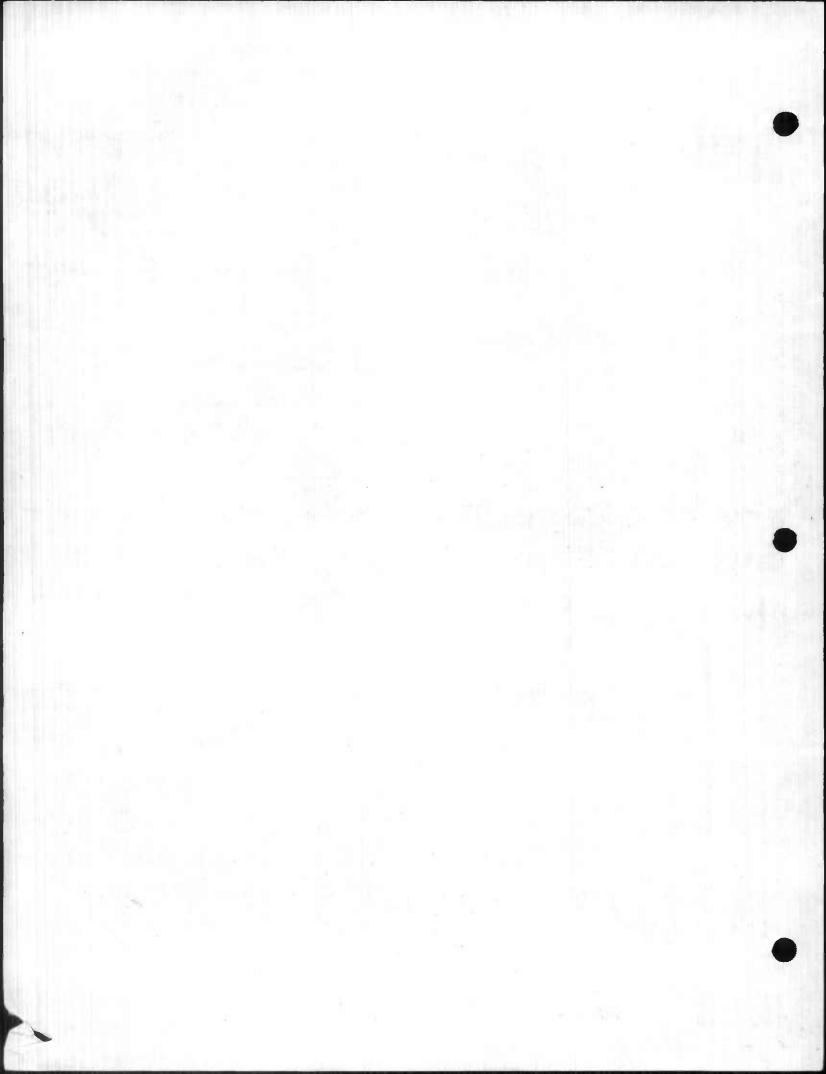


State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director	5. Social Security Number 212-05-6489 Usual Residence of Dec	10	м % Т	7. Age (In yrs. 89	iast birthda Yrs	Months	or 1 Year Days	Hours A	Hrs. 8. Data of (Month) Augus	Day Ye	910	9. Birthpl Count Mary	lece (State or Foreign) I and	gn
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altimore,	Pages 1 nent of He ant: If Ren ary or oth	20a. Method of Dispositi 1 Burlal 2 Dore 4 Donetion 5 D		nemoval from S	ciate Gr		sposition (Ne crametory or Dunt C			8/23/00		Location -		wn, State Maryland	
Ball	Departi Departi Import any inj ence	21 Someture of Funera	militure of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. Approximate												
4	Physician	23a. Part1. Enter the di shock, or haart fail	Sa. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.												
	/Medical	Immediate Cause (Final disease or condition as 06structive lung disease												years	>
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sion	Ne Hospital or Attending Physician: n 24 hours after death. Ne Funeral Director: After this certifica- pletely filled in by the funeral director, edical Certification: To Be (27. Manner of Death 1										/			
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	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b Medical Certi		Certifying Phys Medical Examin		sis of examine										
	within To the compl	29b. Signature and filled discribing 29c. License number 29d. Date signed (Month													
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	8	30. Nama and address of A. P.	of person who be	GBM(of digith (Iter	m 23a) (Ty	pe, Print)	ho	les S	1. B	alte	s. m	195	1204	
1	State	AUG 2 4 20	ay Year)	32. Re	gistrar's Signi	atura do	ach								



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Da. Mathod of Disposition 1 Deurial 2 Deremation 3 December 2 December 2 December 2 December 3 Dec	Genesis E	Eldero							2180			
20a. Mathod of Disposition 1												
21. Signature of Puneral Service Licensee Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, Approximata												
equentially list conditions, any, leading to immediata ause. Enter Underlying ause (Disease or injury at initiated events isulting in death) Last	b. <u>Cory</u>				Day	5	Tacla	adar go				
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art II. Other significant conditions of												
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4 Homicide	building, at	tc. (Specity	")				City or Ti	own, Stata)				
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b. Signature and titla of certifier	A	7/	0	29c.	License	e number		29d. Date signe	d (Month, L	Jay, Year)		
1/	1/1/	1		D39	813			3/18	Tes			
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)												
MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804												
92	Was case refarred to medical axaminer? 1 Natural S Pending invastigation of Death 1 Natural S Dending invastigation of Death 2 Accident 3 Suicide 6 Could not detarmined 4 Homicide 1 Certifying P (Check only one) Medical Examined 5 Signature and titla of certifier Name and addrass of person who	was case refarred to medical axaminer? Manner of Death Manner of Death	was case refarred to medical axaminer? Was case refarred to medical axaminer? Hospital: Due to (or d. was case refarred to medical axaminer? Was case refarred to medical axaminer of Death 1 Natural 5 Pending invastigation 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death (Check only one) 1 Certifier 1 Certif	was case refarred to medical axaminer? Was case refarred to medical axaminer? Hospital: Inpatient Injury Inju	was case refarred to medical axaminer? Was case refarred to medical axaminer? Hospital: Impatient Impatie	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of):			



Sichard

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 1:10 P 22-00 Richard Lewis Evans /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 5. Social Security Number KIVERSIJ ARFORT 2 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10 M 2 F 88 Director 348-01-6046 Alaska **Usual Residence of Decedent** with the Manyland 10s State 10b. County 10c. City, Town or Location -how 10d. Inside City Limits r 28a-f ehow Director 1 ☐ Yes 2 XNo Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or Apt 300 21014 United States 300 West Ring Factory Rd deeth v Funeral 12. Was Decedent Ever in U,S.
Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Depertment of Hailth and Mental Hygiena.
Important: If New 27 Ia marked other than "natural". or in-page injury or other traumatic avairable. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: p Specify 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Salesman Steel Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Ralph P. Evans Minnie C. Spelts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 947 GlenAngus Drive Bel Air, MD 21015 Ronald L. Evans / son 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) 8/24/00 Chesapeake Crematory, Inc.
22. Name and Address of Facility Beltsville, MD 21. Signature of Funeral Service Licens CAFA Stephen D. Lohrmann, P.A.
8717 Green Pastures Dr., Towson, MD 21286

23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately

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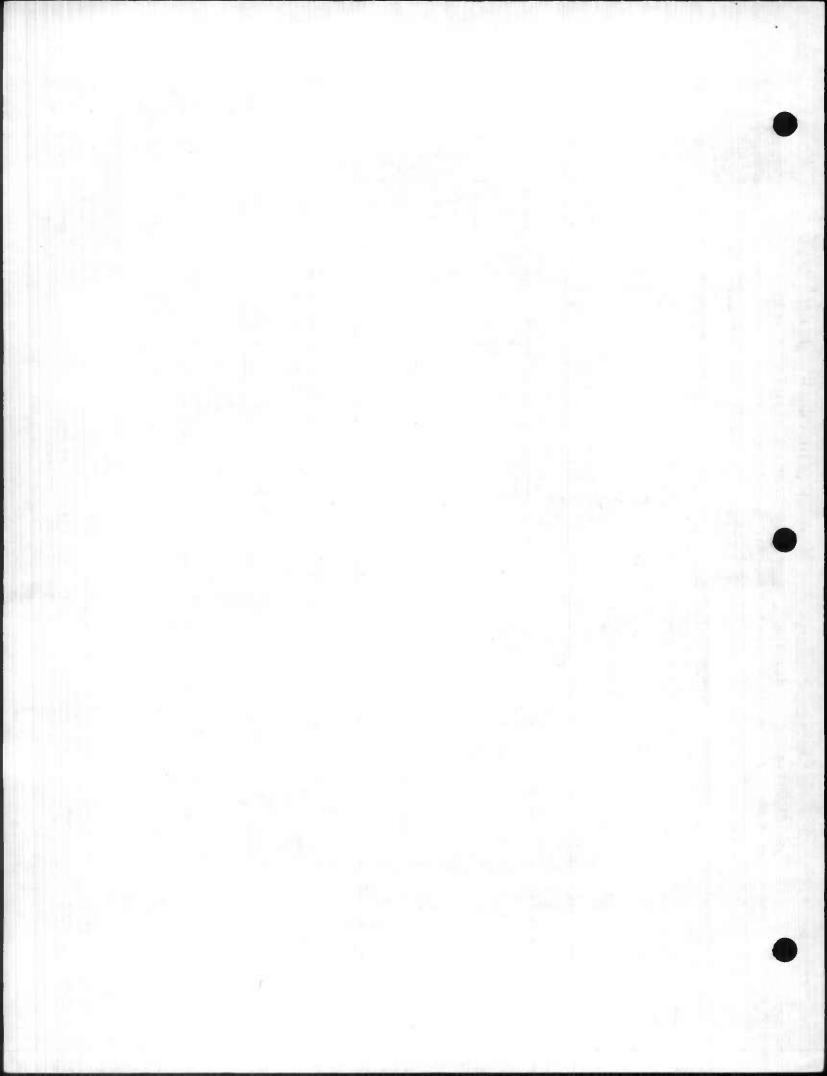
CAFA Stephen D. Lohrmann, P.A.

8717 Green Pastures Dr., Towson, MD 21286

Approximately

pproximate Interval Between Onset and Death **Physician** nyocardial infanction /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician and burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial P.O. Box 68760. Physician/Medical Due to (or as e consequence of): been signed by the a should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? OPD (revere) 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: director. 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) To. DE No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes After this funaral Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation death. **Q** □ Accident 1 Tyes 2 No e Hospital or Attending 24 hours after death e Funerel Director: A 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner es stated.

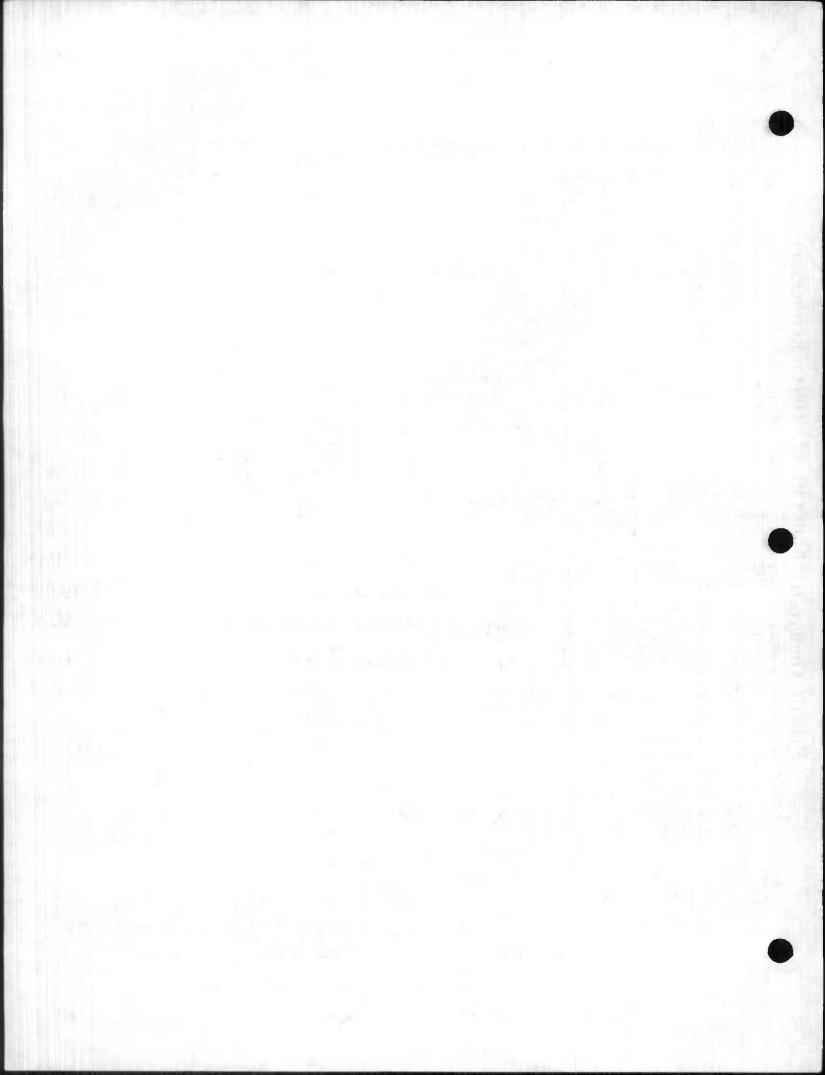
2 | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner stated. 29a. Certifier edical within 2 å 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mac Phail noun 31. Date filed (Month, Day, Year) 32. Registrar's Sigpature State AUG 2 4 2000 oaks Registrar



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State of Maryland / Department of Health and Mental Hygien 0 26867

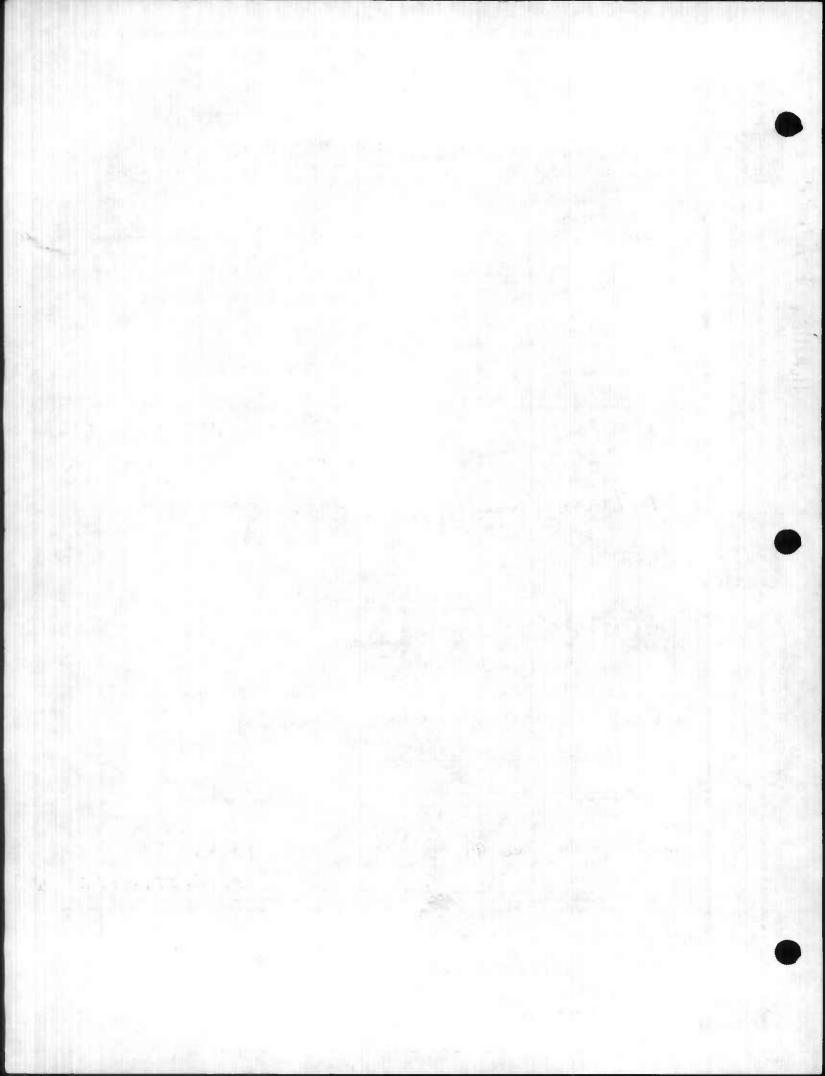
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Physician // // // // // // // // // // // // //	Kenn	21,20							
Examiner	4a Facility Name (If not Institution, give street a			4b. City, Town, or Locati		4c. County of De	eath		
43	Sinai Hospital o	4 Baltimore		Bautim					
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthde	Months Davs	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	9. 8	Birthplaca (State or Foreign Country)		
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D ≥	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits		
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vith the Mai	Md N/A	Daicillo	10f. Zip Code		100	. Citizen of What (Country?		
n with the Maryle at the notified at	2800 Ulman Avenue		21215			SA			
× 11 0	11, Marital Status 12. Wa	s Decedent Ever in U,S. 1		Hispanic Origin? (Specify an, Mexican, Puerto Ric			nerican Indian,		
- 5 £ 6	1 Never Married 2 Married 1 □	Yes 2 No			an, etc.)	Black, Wi	hite, etc. 31ack		
#27 0427 21215-0020 d within 72 hours after piene, return 72 hours after than "netural", or the the Medical Examine	3 ☐ Widowed 4 ☐ Divorced Yes	es, Give ar or Dates:	1 ☐ Yes	Specify:		Specify:	Tack		
121215-002 ed within 72 hours ygiene, metural, we then "netural, it, the Medical Ex Commissed by	15. Decedent's Education (Specify only highest grade comp	letect) 16a. De	cedent's Usual Occup	pation during most of working	166	b. Kind of Busines	ss/Industry		
121 121 121 121 121 121 121 121 121 121	Elementary/Secondary (0-12) Col	llege (1-4or 5+)	e. DO NOT use retire	d)					
d 21	11th grade	N/A		N/A 18. Mother's Name (First, Middle, Maiden Sumame)					
be filed that Hyg d other event,	17. Father's Name (First, Middle, Last)					den Sumame)			
ore, Marylances 1 and 2 should be to of Health and Mental Filtern 27 is marked of r other traumatic even				Cora Alst					
Maryland 212 Maryland 212 d 2 should be Illed within the and Mental Hygiene. T is marked other than traumatic event, the Maryland To Be Comment	19a. Informant's Name/Relationship (Type, Pri			t and Number or Rural R			a, Zip Code)		
CONE	Alexander Henderson- 20s, Method of Disposition		O Ulman Av		-	dd 21215 c. Location - City	or Town State		
Baltimore, semil. Pages 1 at Department of Hea mportant; if terming light my lajury or other and last my lajury or other and last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my lajury or other last my last my lajury or other last my l	1X Burial 2 Cremation 3 Remova	I from State cametery, o	Cemetery Cemetery	ca)		ansdown,			
ting the beautiful than than than than than than than than	4 Dondtion 5 Other (Specify)	ilisuowii,	riu						
Baltimo Permit. Pege Department. Important: if Important: if any Injury or	21. Signature of Funeral Service Licarisee	1	March F						
<i>y</i>	Tekone H's	thompson	4300 W	abash Avenu	e Balt	d 21215			
	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the death. Do not see on each line.	enter the mode of dyl	ng, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death		
Physician /Medical	Immediate Cause (Final						.7 1000		
Examiner	disease or condition resulting in death) a.	5ep	5 5				2 acrys		
		Due to (or as a con	sequenca of):				5 months		
owecuted in and its transit	b	Due to (or as a con-	Toma				J MONTON		
60, be executed iclan and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury	al a cod Mat		isturbance	· C		2 dans		
68760, fileate be see physician as the burial-	that initiated events	Due to (or as a cons		Sturmine	>		7.0043		
- E Od 2	resulting in death) Last	_		sease			3 years		
Box Beath cert	d	grasiage n	am si	xusc			1 o years		
S, P.O. BO) So that the death ce goed by the attend be detached for us, by Physician	Part II. Other significant conditions contributing	g to death but not resulting in the	e underlying cause gi	ven in Part I.	23b. Dld toba	cco use contribu	ute to the cause of death		
P.O. That the control of by the descent					1 Yes	2 No 3 🗆	Probably 4 Unknow		
al Records In lease requires cate has been sign page 2 should be					24a. Was an a performed		b. Were autopsy findings evailable prior to		
Rec elaw hesb	21 444						completion of cause of death?		
The Late he page	and the second				1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No		
/it	25. Was case referred to medical			26. Place of Death (C	check only one)				
Physic of this control direction.	1 Yes 2 No Hospita	1 Inpatient 2 LI ER/Outpa	Itlent 3LI DOA	her: 4 Nursing Home			pecify)		
Division c that or Attending P is after death. al Director: After to led in by the (uners	27. Manner of Death 1 Natural 5 Pending	. Date of Injury (Month, Day Year) 28b. Time	ry Wo		I. Describe how	injury occurred			
Vision Attending In death. ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	Leasting (Care	at and them become	Dural Carta Musebar		
Divisi	4 ☐ Homicide determined 286	. Placa of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	281	City or Town, S		Rural Route Number,		
DIVI To the Hospital or At within 24 hours affer To the Funeral Direct completely filled in by		To the best of my knowledge, de	noth convered at the a	ime date and slave see	due to the arm	20/2) 204	an stated		
To the Hospital within 24 hours a To the Funeral IC completely filled	(Check only 2 Medical Examiner: Or	and place, end o	due to the cause(s)						
To the within 2 To the comple	29b. Signature and title of cartifier	d manner stated.	se number	29d.	. Date signed (Mo	onth, Day, Year)			
F3F8	1 Lamonto	nn	06	5 000	1		21,2000		
00	30 Name and address of passes who appropriate	d cause of death (from 22a) (T.	no Print'		F	rugusi	01/1000		
(V)	30. Name land address of person who completed cause of death (Item 23a) (Type, Print)								
State	31. Date filed (Month, Day, Year) AUG 2 4 2000	32. Pregistrar's Signature		C1 1 (001 91	COLICA				
Registrar	AUG 2 4 2000	Deneva 19	Acres de						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

26868 Certificate of Death Amended Item#28b, 28c perMEO G786 8/24/2000 EW 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** August
4b. City, Town, or Location of Death Beatrice C 5:34 AM Hurdle 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Center | If Under 1 Year OSedale HUnder 24 Hrs. A Dal Salt: more Franklin Square HOSPITAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 200 F 217-12-9115 Director July 28 1923 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 ☐ No **Baltimore** Directo Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 510 N Stuart Street 21221 Funeral TISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 25 Merried 8 Maryland 21215-0020 1 Yes 2€ No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Clerk 9th other's Name (First, Middle, Last) Crown Cork & Seal Co. 18. Mother's Nama (First, Middle, Maiden Sumame) Martin Stromer Schweiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Health Ham 27 Edwin Hurdle / husband 510 N Stuart Street Baltimore Md. 21221 Baltimore. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete Gardens of FaithCemetery8/14/2000 4 ☐ Donation 5 ☐ Other (Specify) Rosswille 22. Name and Address of Facility Connelly Funeral Home Connelly onne 300 Mace Ave. timoral Mar. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ways Examiner Dua to (or as a consequence of): Physician/Medical Examiner wound Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants reaulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be exec Box 68760. omonths Fracture Due to (or as a consequence of): la months Due To Fall P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Anteriosclerotic Cardiovascular Disease Division of Vital Records. Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Osteo porosis 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was casa referred to medical examiner? 26. Placa of Daath (Check only ona) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 No /s after dear-ral Director: After br. by the funeral dir 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Attanding 5 Pending investigation 1 Natural Dec. 99 1 Yes 2 No Unknown standing Then 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State)
510 N. STUART ST. M 28a. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicida 8 AT HOME within 24 hours To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the best of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state: edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DC024883 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 9000 Dr. Ricardo Cook Franklin Square Orive Baltimore, MD. 31. Dete filed (Month, Day, Year) 32. Registraris Signeture State AUG 24 Registrar



The law requires that the death certificate be execu Box 68760, P.0. Records, Division of Vital

Physician

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Pages 1 and 2 should be finent of Heeith and Mental I int: If Item 27 is marked of

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Department of Important: If eny Injury or

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21215-0020

Baltimore, Maryland

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or Attending Physician: After this 24 hours after death. Hospital within 2 To the F \$

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Medical Certification: To State Registrar

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TO-Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

29d. Data signed (Month, Day, Year) AUGUST 22 2000

30. Nama and marass of person who completed cause of death (Item 23a) (Type, Print)

RANDAUSTOWN MD 21133 5401 OLD COURT RD mo ROBENS ANE.

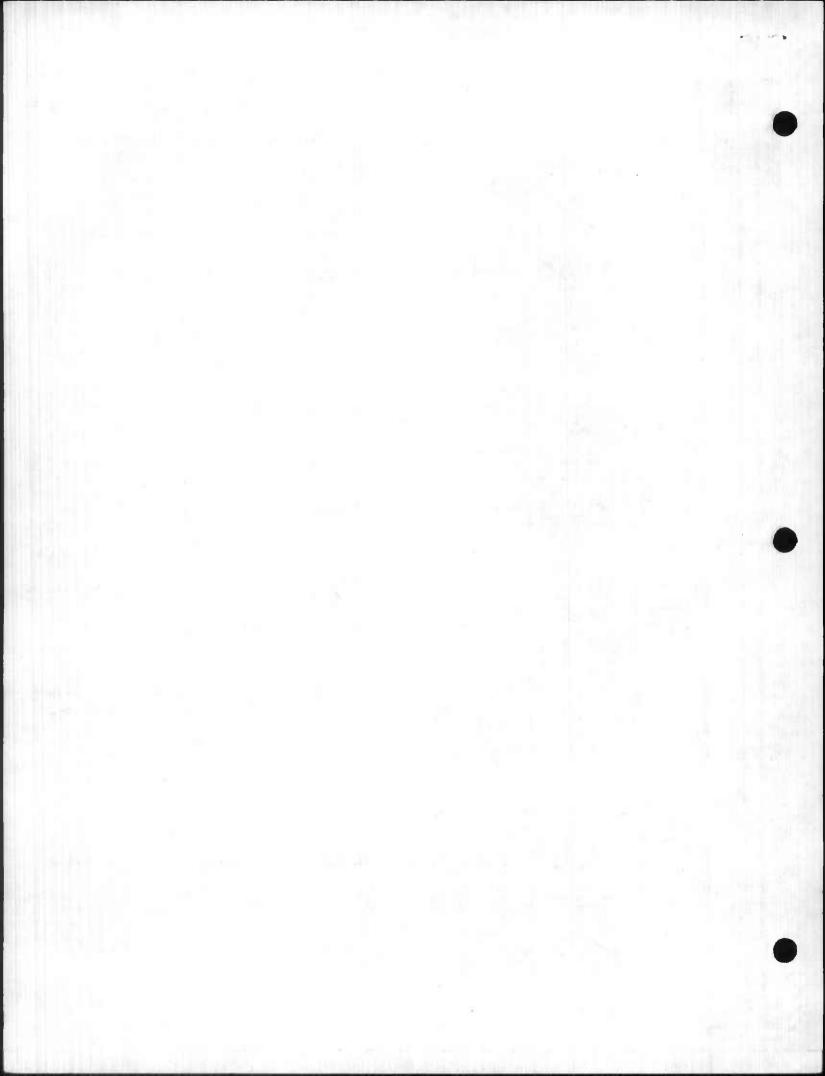
31. Data filed (Month, Day, Year)
AUG 2 4 2000

29b. Signatura and tillio of condition

32. Registrar's Signatura

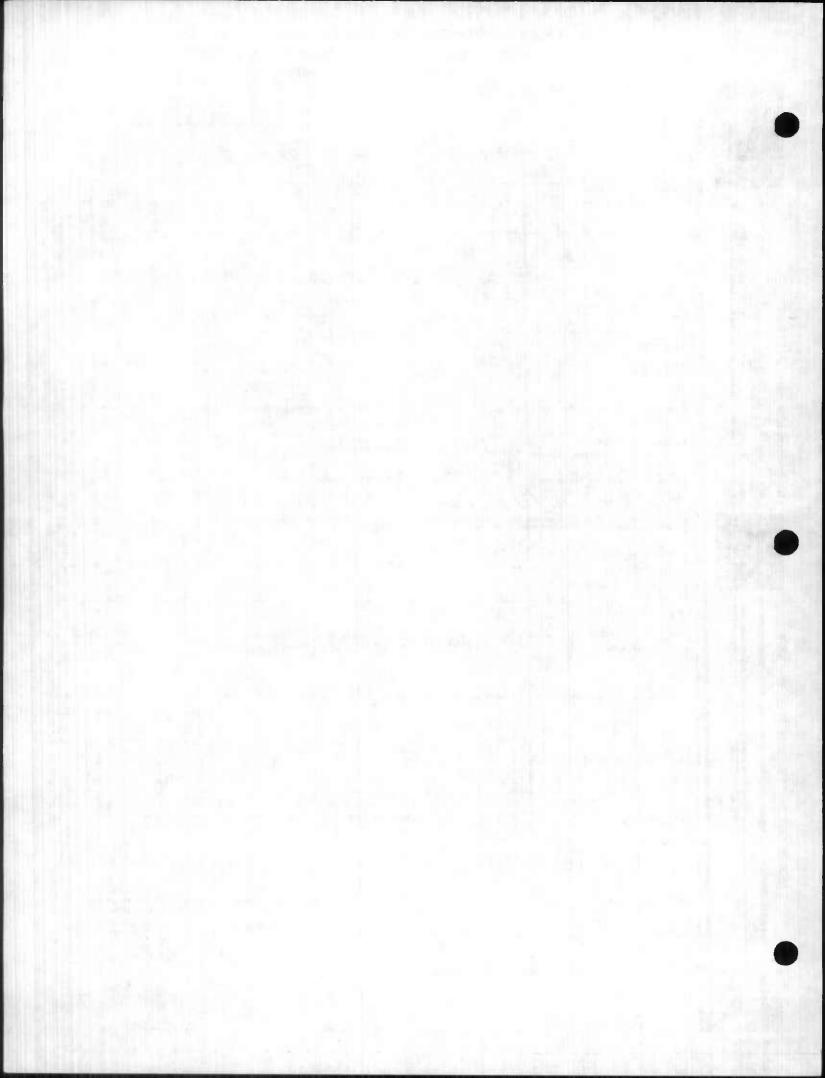
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29a. Certifier (Check only one)



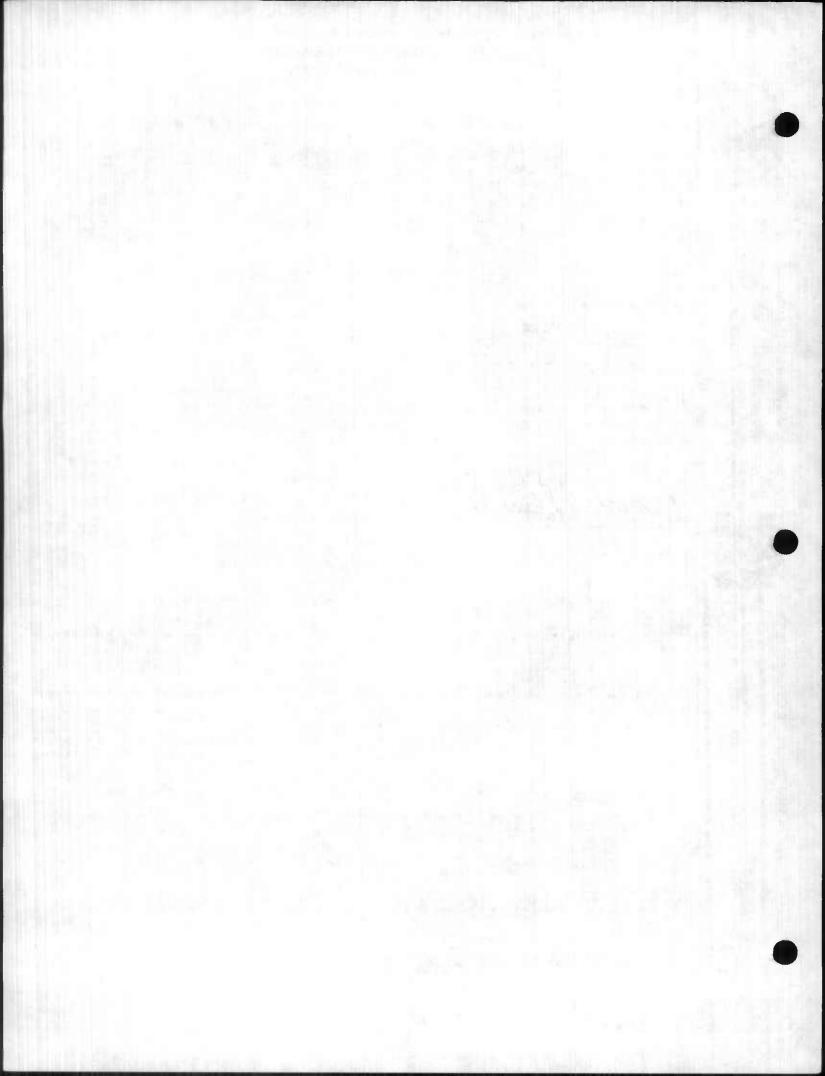
State of Maryland / Department of Health and Mental Hygiene 00 26870

			C	ertificate of	Death		leg. No.			
Physician	1. Decedent's Name (First, Middle, L					2. Defe of Dea Month	fh Dey	Year	3. Time of Deeth	
/Medical	RUTH MAE JARI				4b. City, Town, or L	August		2000	1225	
Examine	4a Facility Nama (If not institution, g	ive street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death		
	The Memorial				Easton		Talk			
Funeral Director	215-12-6682	Sex 1 M 2 F 7. Age	(In yrs. last birthda 78 Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day Jan 30,	Year) 1922	9. Birthpli Count	ace (State or Foreign (ry) DEL	
Mand Mand	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	Location				10	Od. Inside City Limits	
or 28s-f st or 28s-f st be notified	MD Card	line		Denton					1 ☐ Yes 2X No	
				10f. Zip Code			10g. Citizen of V	Vhat Count	ry?	
the said	520 Kerr Avenue	12. Was Decedent Ev	tor in IIC 1	Was Decedent of	21619	posity Vac or No.		SA e - America	an Indian	
ors at	3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 X Yes 2 No if Yes, Give Year or Dates:	rei in O,S.	3. Was Decedent of If Yes, apecify Cub 1 ☐ Yes 2 No		Rican, etc.)	Blac	k, White, e	etc.	
72 hg	15. Decedent's E (Specify only highest g	Education rade completed)	16a. De (Gi	cedent's Usual Occu ve kind of work done DO NOT use retire	pation during most of work	king	16b. Kind of Bu	siness/Ind	uatry	
ed within 72 hours at Ygjens, we than "natures", or it, the Medical Exami	Elementary/Secondary (0-12)	College (1-4or 5+)) life	. DO NOT use retire			-	insura	ance	
Hygin Hygin		t)		500100	18. Mother's Nem	e (First, Middle,		-		
Mental H Mental H what off affic ever	William H. Jarma	an			Cora	M. Foulk	ces			
2 sho and 3 is ma	19a. Informent's Neme/Relationship Memorial Hospita			iling Address (Stree S. Washi						
emil: Pages 1 and Department of Health Recelant: If item 27 any injury or other 27 ance.	20a. Method of Disposition 1 ☐ Burlat 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Discemetery, c	position (Neme of remetory or other ple	me of Date 20c. Location - City or Town, Stete					
parmit. Departri Imports any inja	21. Signature of Fuyleral Service Lice Ronald S.	Wade, Direc	d 655 1	W. Balt	imore	Street				
Physician /Medical Examiner	23a.Part1. Enter the disease, or consock, or heart failure. List only immediate Ceuse (Final disease or condition resulting in death)	a		psis	ing, such as cardiac	or respiretory an	651,	}	Approximete Interval Between Onset and Death	
executed in and intransit	Sequentially list conditions,	b	ue to (or as a cons	equence of):						
ifficate be g physicle as the bur	Cause (Disease or Injury thef initiated events resulting in death) Last		ue fo (or es e cons	equenca of):						
eath certific attending p of or use as		d					1			
d by the detached	Part II. Other eignificant conditions	contributing to death but	not resulting in the	iven in Part I.	23b. Did t	- M	3 Prob	the causs of death bebly 4 Unknow		
D 00						24e. Was a perfor		cor	ere autopay findings alleble prior to appletion of cause deeth?	
ysician: The law is certificate has b director, page 2 s						1 🗆 Y	es 2 No	1 🗆	Yes 2□No	
ector, p	25. Was cese referred to medical				26. Place of Dea	th (Check only o	ne)			
Physician: this certific	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	2 KER/Outpat	ient 3 DOA OI	hor:	ome 5 Resid		er (Specify	0	
ith. After this stuneral di		28a. Date of Injury (Month, Day)		of 28c. Inju		28d. Describe h				
tal or Attending P is after deeth. In Director: After ted in by the funera	3 Suicide 6 Could not determined		y - At home, farm, (Specify)	atreet, factory, offica		28f. Location (S City or Tow	itreet end Numb n, State)	oer or Rura	Route Number,	
ne Hospi n 24 hou ne Funer pletely fill	29e. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of eminer: On the basis of eand menner state	xaminetion end/or							
To the within To the comp	29h Signature and title of certifler	SHI	MD.	29c. Licen	5 4 75 3 L	4	29d. Date aigne	22	Day, Year)	
1) c/	30. Name and address of parson who was it Zaky,	completed ceuse of dea M.D. 920	oth (Item 23a) (Type Mark	e, Print) et St,	Denton	MD	2162	-9		
State	31. Date filed (Month, Dey, Year)	32. Registrar	's Signature	,						



State of Maryland / Department of Health and Mental Hygiene 00 20071

				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certificate	e of	Death	Reg.	No.	0 2	200/1				
Phy	ysician	1. Decedent's Name (First, Middle Mary Olive Jan					1	2. Date of Death Month	Day	Year	3. Time of Death				
	Medical aminer	4a Facility Name (If not Institutio		er)			4b. City, Town, or Loca		22, 20 4c. County	of Death	11:04 A.M				
EX	ammer	5845 Benton He					Baltimore		N	I/A					
Fun Dire		5. Social Security Number 219-16-8974		Age (In yrs. last b	Yrs. If Under Months	1 Year Days	If Under 24 Hrs. 8	Date of Birth (Month, Day, Ye Dec. 14, 19	ear)		lace (State or Foreign try) and				
8 8		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tov	yn or Location					10	Od. Inside City Limits				
ofh with the Maryla 23s or 28s-f sho	o o			100.00,10		O. 1					1 X Yes 2 □ No				
2 4	octo	Maryland n	ı/a		Baltimore 10f. Zip	-		100	Citizen of W	/hat Coun	trv?				
# B	1 D	5845 Benton Heights	Avenue		15.1.2.4		206			ISA					
or death	iner must	11. Manifal Status	12. Was Decede	onf Ever in U,S.	13. Was Deced		Hispanic Orlgin? (Spec an, Mexican, Puerto Ri	ity Yes or No-	14. Race	- America					
d within 72 hours after- giene. re than "natural", or its	by by	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	₹ No	1 Yes, spec		an, Mexican, Puerto Ri	can, etc.)	Specify	k, White, d	ite				
2 5 M	r, the Medical	15. Deceder	nt's Education est grade completed)	166	Decedent's Usua	k done	during most of working	7	. Kind of Bu						
F 6 5	a de	Elementary/Secondery (0-12)	College (1-4		life. DO NOT us	e retire	d)		Army/Ai						
N Della		10	(net)	Bu	idget Analy	st	10 Mathada Maria		Exchang		/ice				
Maryland d 2 should be file in and Mental Hy 7 is marked other	B Se	17. Father's Name (First, Middle,					18. Mother's Name (
T de de	To	Mark Charles Grab	-	10	h Atallian Address	/Ctrant	and Number or Rural	Anna Burg			Code				
Ma d2s man	tra cr	Mr. Mark Dvorak (201 Woodsto						C004)				
- 5 g %	the c	20a. Method of Disposition	3011)	20b. Placa	of Disposition (Nan	ne of					wn, State				
altimore mit. Pages 1 pariment of Hs	8	1 ☑ Burial 2 ☐ Cremation		110											
4 4 4	E .		Method of Disposition Burial 2 Cremation 3 Removal from State Completery, crematory or other place) Gardens of Faith Cemetery 20c. Location - City or Total Completery Baltimore Main Service Liganus 22c. Name and Address of Facility												
Dep 1	any a	22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Balto. Md. 21214 23a Part Foler the disease of Commissions that such at death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate													
		23a. Part1. Enter the disease, or shock, or heart failure. List	reproductions that cau anily one cause on each	ed the death. Do	not enter the mod-	e of dyle	ng, such as cardiac or	respiratory arrest		1	Approximate Interval Between Onset and Death				
Physical /Media Exami	ical iner														
of fou, ifficate be executed g physician and	is the burial-transit edical Examiner														
the death cery the ettendir	ad for	Part II. Other significant condition	one confributing to deat	h but not resulting	In the underlying c	ause gi	ven in Part f.	23b. Did toba	cco usa coi	ntribute to	the cause of death?				
T to b	detached for use			1 Yaa	2□ No	3 ☐\Prot	bably 4 Unknown								
aw requires	2 should be pleted by							24a. Was an a performe Inspect	d?	EV.	ere autopsy findings ailable prior to mpletion of cause death?				
The law	Com							1 🗆 Yes	2X No	10	Yes 2□ No				
VITAL Victoria Certificate	Be C	25. Wes case referred to medica examiner?	ıl				26. Place of Death	(Check only one)							
Of VICE Physician: rthis carific	0 2	1 Yes 2 No	Hospitel: 1 ☐ fnp	atient 2 ER/C	utpatient 3 DC	A Ott	her: 4 Nursing Hom	e 5 Residenc	e 620th	er (Specif)	at scene				
Attending Physic death.	62	E LI MOCIOSIN	28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work? 1 Yes 2 No												
DIVISION of or Attending s after death. I Director: After	ed in by the funera Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Place of	Injury - At home, i etc. (Specify)	arm, sfreef, factory	, office	28	If. Location (Street City or Town, S		er or Rura	I Route Number,				
DIVISION To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After	pletely fille edical (ng Phyaician: To the be Examiner: On the besis and manner	s of examination a											
To the Within To the	Me	29b. Signatura and fitte of certifie	or A		290	. Licens	se number	29d	Dafe signe	d (Month,	Day, Year)				
	1	Atack	12/0	ch.	MD.		O.C.M.E.	Au	gust :	23, 2	:000				
,	10	30. Name and address of person	0 1	of death (Item 23a)		n St	reet, Balt								
	State	31. Date filed (Month, Day, Year)		istrer's Signature	, ,				1						
Re	State gistrar	AUG 24		neva ,	y Spo	uks	1								



State of Maryland / Department of Health and Mental Hygiene 26872 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death KNOEPFLER **Physician** GLORIA AUGUST 2000 11:43 A.M. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE 3001 SOUTH HANDVER last birthday) If Under 1 Yaar If Under 24 Hrs 8. Data of Birth (Month, Dev. Year) 9. Birthplace (State or Foreign Country)
July 19, 1928 Washington D.C. 9. Birthplace (State or Foreign 72 **Funeral** 1□M 2\ F Days Yrs. 579-34-2529 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location t 0d. Inside City Limits MD Anne Arundel Linthicum 1 ☐ Yes 2 No Director "natural", or fisma 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or itsma 23a or the Medical Examiner must be 6100 Medora Rd. 21090 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Yeer or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11 Merital Status 72 hours after 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3℃ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coflege (1-4or 5+) Homemaker Own Home 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be should be nd Mental Samuel Lewis is marked Mildred Lucruce Graham 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) of Health an Hearth an Richard L. Knoepfler, son 6100 Medora Rd. Linthicum, MD. 21090 Saltimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State Pages 1 important: If the any injury or o 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Steta Mt. View Cemetery 8-26-00 Marriottsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. rebecco 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on aech lina. Approximate Interval Batween Onset end Deeth **Physician** Immediate Cause (Final disaesa or condition resulting in death) **IMedical** SHOCK Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury The law requires that the death certificate be execu UPPER GASTROINTESTINAL BLEEDING FOUR DAYS Box 68760. Physician/Medical thet initieted events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use gontribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown THE LEFT þ 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was en eutopsy periormed? 1 ☐ Yas 2 ☐ No 1 Yea Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Npatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury et Work? 28d. Describe how injury occurred apital or Attanding Prours after death.

neral Director: After t 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homiclde To the Funeral Completely filled Hospita 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certitier edical (Check only one) 100 FIRST YEAR 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signatura and titla of cartifian RESIDENT P13470 AUGUST 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED ALATTAR

11. Date filed (Month, Day, Year)

AUG 2 4 2000

32. Registrar's Signature 21225

DHMH 16 Rev 6/95

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Katherine KedziersKi 08 20 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Death Baltimore Shock rauma Center If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Mary Land 5. Sociel Security Number 7. Age (In yrs. lest birthday) Days Hours 1 M 2K F 212-42-7077 55 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Dundalk Baltimore Maryland 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 21224 United States 529 Southern Avenue 14. Race - American Indien Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☒ Merried 1 Yes 2 No Specify: specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Johns Hopkins Bayview 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Samuel (Unknown) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 Southern Avenue Edward K.Kedzierski, Jr./Husband Dundalk, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 I Cremetion 3 ☐ Removel from State Chesapeake Crematory, Inc. 8/22/00 Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee CAFA Stephen D. Lohrmann P.A. andost 8717 Green Pastures Drive Baltimore, MD 21286 aura 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequenca of) ablte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initialed events resulting in death) Last Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee ZNNo 3 Probably 4 Unknown 24e. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 203 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Examiner attending physician for use as the buna Division of Vital Records, P.O. Box 68760, this certificate or Attanding Physician: After death. Director:

Physician

/Medical

Examiner

Funeral

Director

must be notified at

"natural", or hams 23s or 28s-f

Department of Neath and Merical Physics important: If New 27 is merical regularly influence of the regular and injury or other regular and inj

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

Directo

Be Completed by Physician/Medical edical Certification: To

within 24 hours a To the Funeral C

Hospital

Registrar

31. Date filed (Month, Day, Year) AUG 2 4 2000

29b. Signeture and title of certifier

4 Homlcide

29a. Certifier (Check only

> South Greens 22

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner as steted.

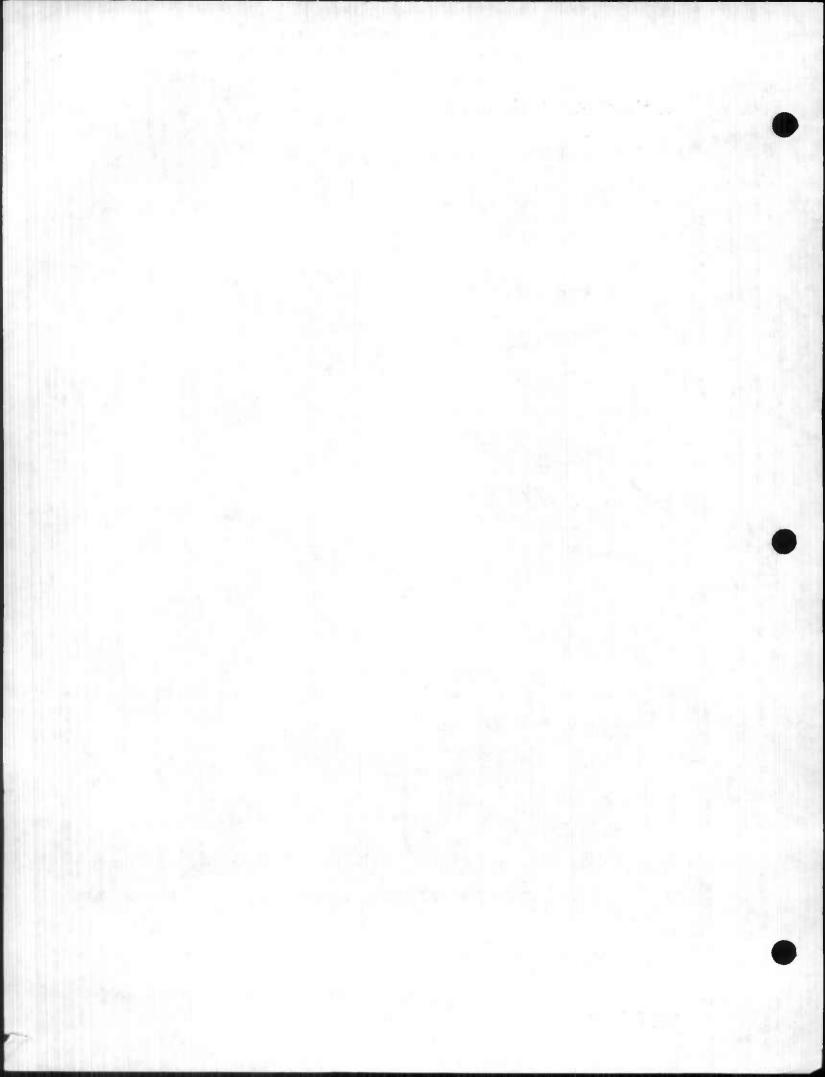
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

29d. Dete signed (Month, Day, Year) Augest 20, 2000

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) John A Bruten

32. Registrar's Signeture



Registrar

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32. Registrar's Signature

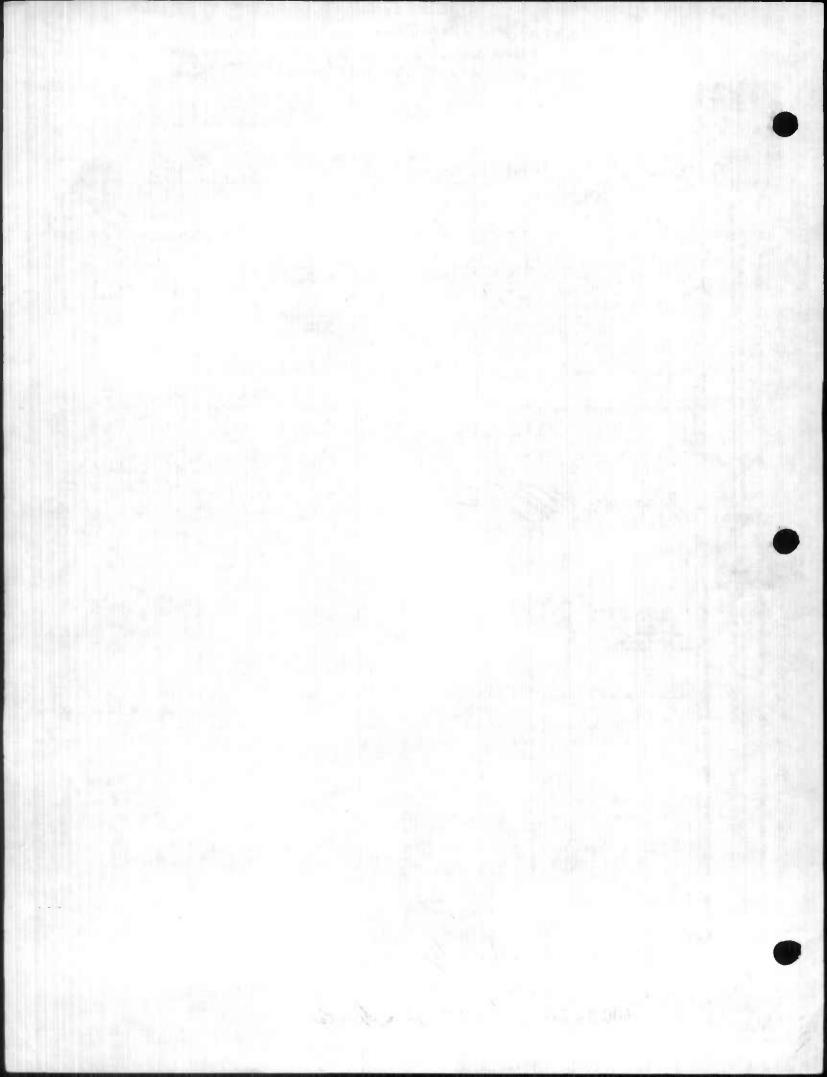
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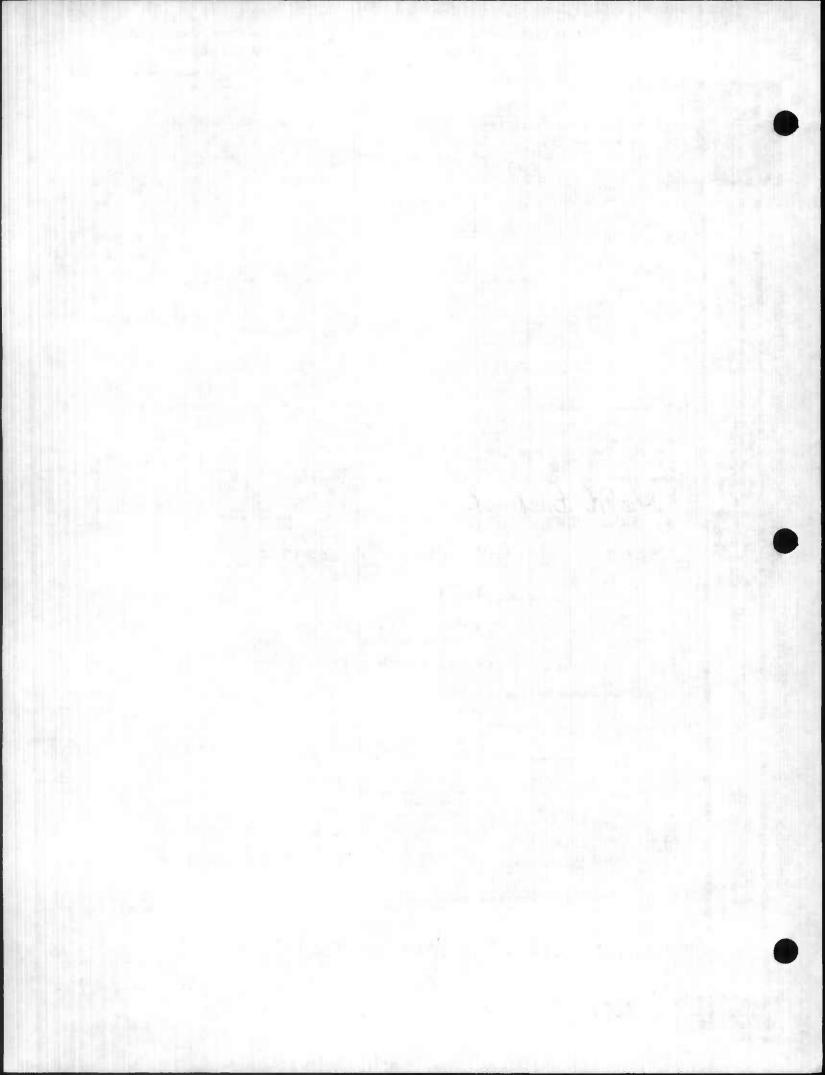
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ichael E			State of Maryland, 27, 28A-F	/ Department	of Health and I	Mental Hygi	iene 00	2687	5
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	dical niner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or I	ocation of Deeth	4c. County of C	Death	
(4)			glish Oak Road	Williadas	Parkvi.l			imore	
Funer Direct		5. Social Security Number 6. Se. Usual Residence of Decedent	7. Age (In yrs. las	t birthday) If Under Months Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	Year 9.	Birthplaca (State or For Country)	reign
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		30. Name and address of person who co			O.C.M.E.			t 22, 2000	
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	or 28a-f s be notified	10e. Street and Number			10f. Zip Coda	- 15 M		10g. Citizen of W	hat Country?		
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Maryland 21215-0020	ad within 72 ho ygiene. ser than "naturn r. the Medical Completed	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)	Education grede completed) College (1-4or 5	(G	cedent's Usual Occupive kind of work done e. DO NOT use retire	during most of work	king	16b. Kind of Bus	siness/Industry		
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Division	or Attending after death. Director: After in by the fune ertification	27. Manner of Death 1								Number,	
	To the mospital or Attending Physician 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To		Physician: To the best of aminer: On the basis of and manner sta	examination and/o						iuse(s)	
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	-	30. Nama and address of person who completed cause of death (Item 29a) (Type, Print) 224 CHESA CON AVE, BATIMORE, MD 21237 31. Date filled (Mapple, Peryorear) 2000 32. Redistrar's Signature									
	State Registrar	AUG'2 4	2000	is Signature	9 sport	5					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month ROSIE Physician 4 P.m 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town or Location of Deeth 4c. County of Death Examiner HARford Rehal Dal to If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) GARDEN If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Months Days 218 18 73401 Yrs. Director **Usual Residence of Decedent** 10c. City, Town or Location
Bol 10 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryle Department of Heelth and Mentel Hydiens. Important: If item 27 is marked other than "natural", or home 23s or 28s-f show eny injury or other treumatic event, the Medical Examiner must be notified at 9000s. N. T 1 XYas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 E. O liver 5.9 21213 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baitimore, Maryland 21215-0020 Specify: Black Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) FORT Holabird LAboter L 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Un Known Known 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) E. Olmer DI Balto. md 21213 MON 1R65 MC Dowe 20b. Place of Disposition (Neme of cemetery, eremetery or other to 20c. Location - City or Town, State

Ballo Ma 20a. Method of Disposition 8/26/00 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Lem 4 Donation 5 Other (Specify) IMORE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee doces Rock 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) . END STAGE CARDIOMYOPATITY MONTET Examine Due to (or as a consequence of) Examiner CORONARY ANTERY DISEASE physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): 007 signed by the sid be deteched f Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to Completed 24e. Was an eutopsy performed? completion of cause of death? 1 Yas 2 No 1 Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1□ Yes 20 No Other: 4 Defining Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours effer death.

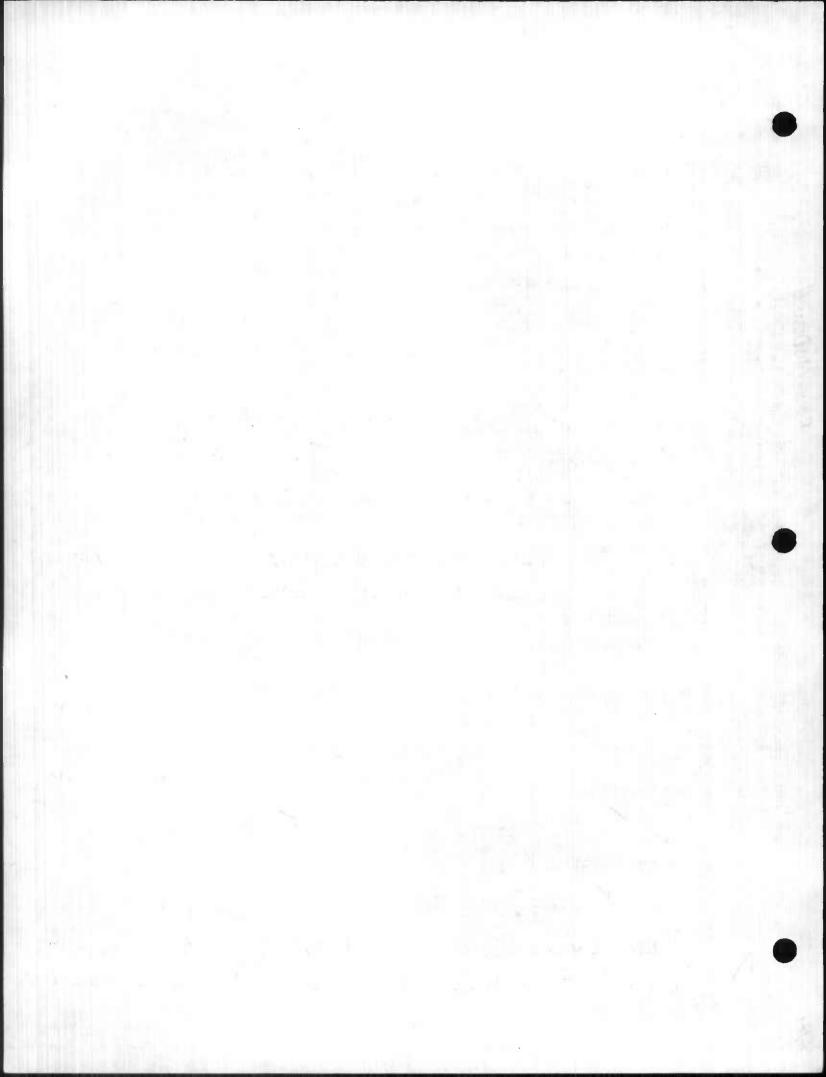
• Funeral Director: After thisietely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Divatural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 22.2000 completed cause of death (flem 23a) (Type, Print) Parkitey hts Avonue Baltimone. MD 7220 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

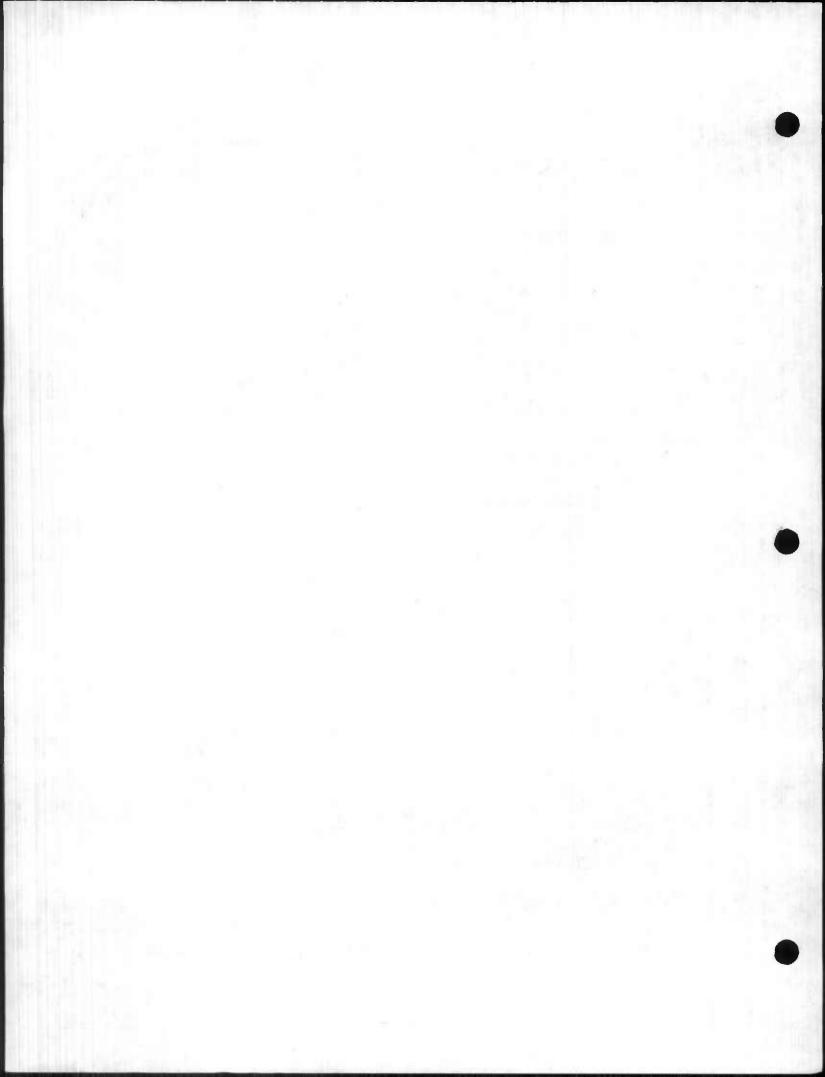
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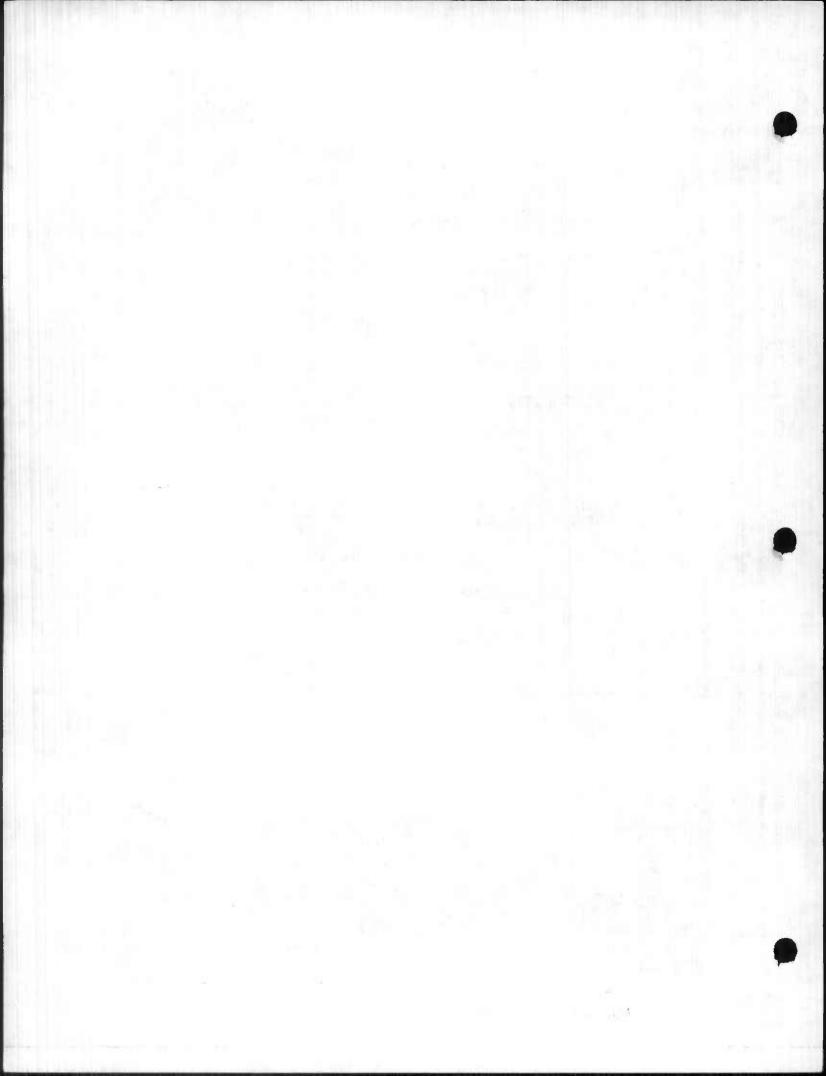


State of Maryland / Department of Health and Mental Hygiene

CHARLES MC SWAIN CHARLES MC S						Cer	tificate	of Death		F	leg. No.	U	268/1	8		
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer Physician 2.05 AM August assher enne 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Head KER'S en tes Salisbury Wicenucc If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 11 M 2□ F 65 Yrs. 213-32-2403 Dec 14, 1934 Director MD Usual Residence of Decedent the Maryland 10b County Dorchester 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Cambridge 1 ☐ Yas 2X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with or Herns 23a or 3011 N. Skipjack Drive 21613 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after man of Healin and Mental Hyglens. In: If item 27 is marked other than "natural; or the ury or other traumatic avent, the states. 21215-0020 1 Yes 2 No Specify Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) supervisor plastics Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Paucratious J. Nassner Anna M. Kisper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Angela Robinson/daughter 3011 N. Skipjack Drive Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or page. 4 Donetion 5 ☐ Other (Specify) 21. Signatule of Euperal Service License Konald S. 22. Name and Address of Facility State Anatomy Board Wade Director 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Be Completed by Physician/Medical Examiner The law requires that the death certificate be asscuted be detached for use as the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thel initieted events resulting in death) Last and Due to for as a conse 23b. Did tobacco usa contributa to the causa of death? Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yea 2 No 24b. Were autopsy findings available prior to completion of cause of death? Ilisus icienc 24a. Was an autopsy page 2 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, Division of Vital Records, P.O. or Attanding Physician: within 24 hours after death. To the Funeral Director: A the filled in by To the Hospital completely

29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0016278 hrestho

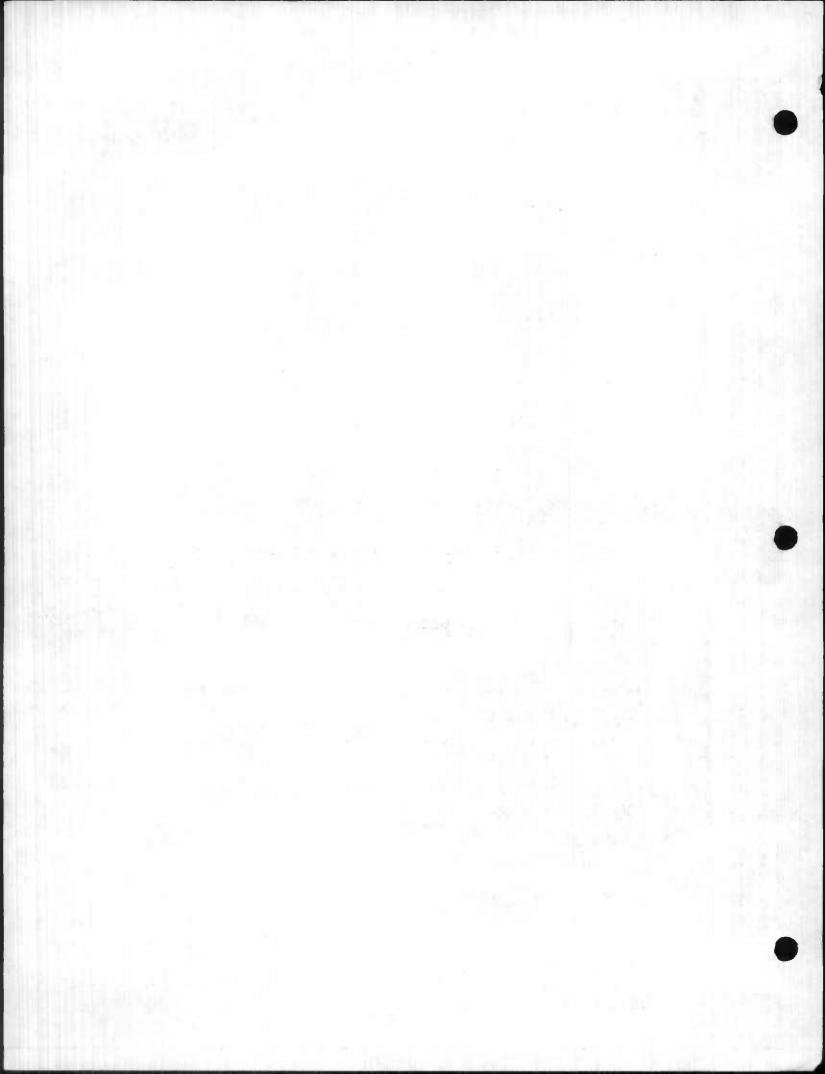
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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32. Registrer's Signature

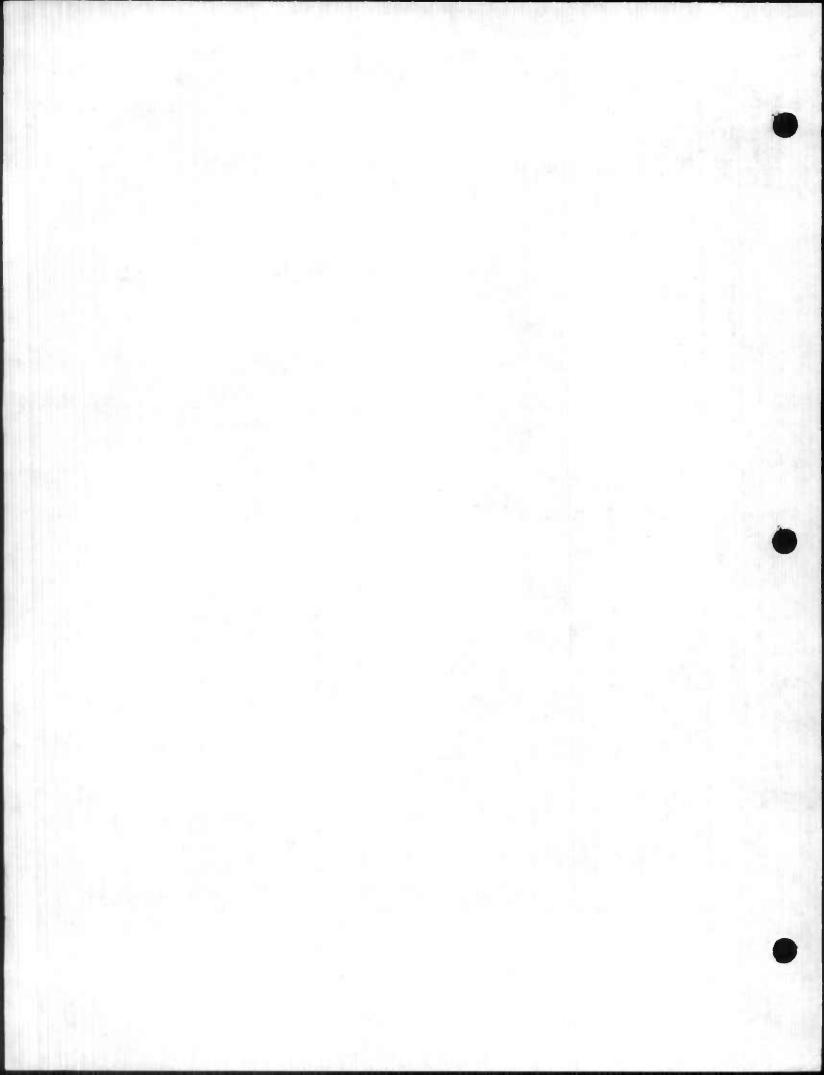


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

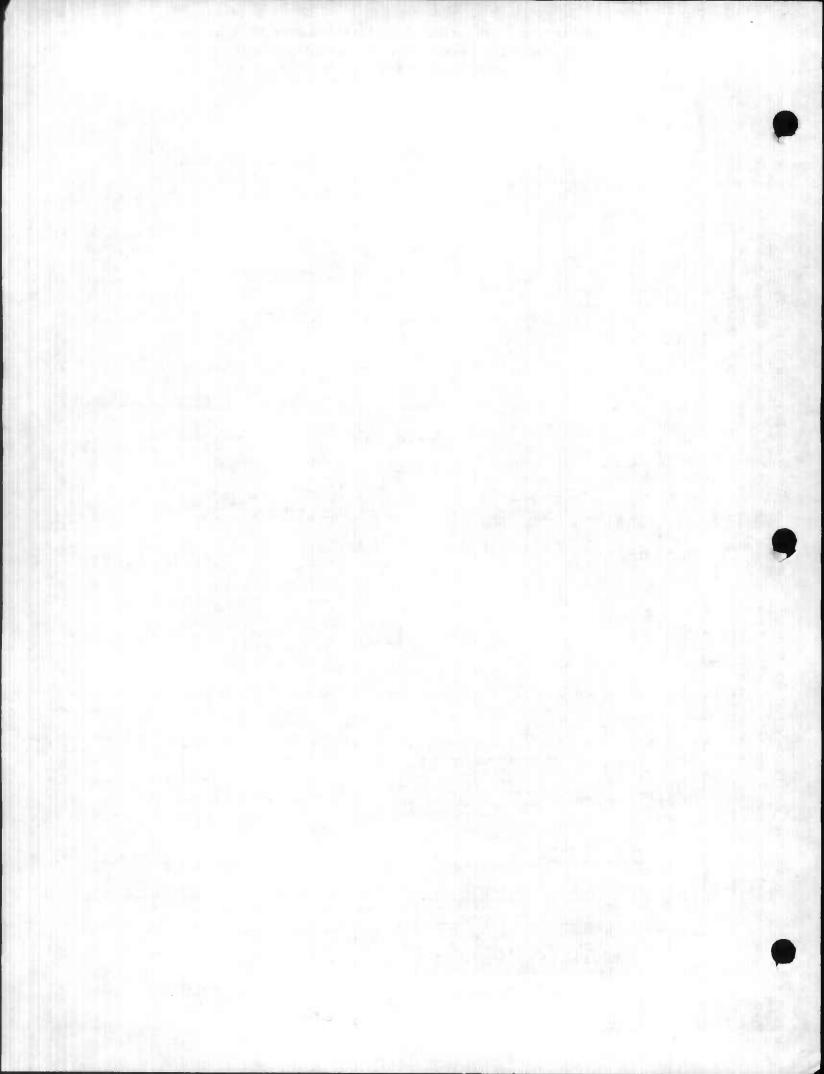
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Examin		4a Facility Name (If I	not Institution, giv	1	Cen	ter				BALL	imo	ocation of Death	4c. County			
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al or Att s after d il Direct ed in by	Certifi	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Pla	ce of Injur Iding, etc.	ry - At home (Specify)	, farm, str	et, facto	ry, office			28f. Location (S City or Tox		ber or Aur	e/ Route Nu	mber,
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_	005 4 0		o year			1	407	old I	Easter	m A	venue, E	ssex,		_	
	Physician /Medical Examiner		23a. Part Lenter the disease, or com- index, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	CARDIA.	AC A	RRHYT	HMIA							Intervet Bet Onset and	
٦	be is	nine		b	OSCL	EROTI	C CA	RDI	OVAS	CUL	AR DISE	ASE	1		
60,	par par	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c	Due to (d	or es a conseq	uence of):								
Box 68760,	5 2 5	Physician/Medic	thet initiated events resulting in death) Last	d	Due to (o	r as a conseq	uence of):								
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Division	tal or Attendit is after death. al Director: Al led in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuditions, etc.	ury - At h	ome, farm, str (y)	eet, factor	y, office			28f. Location (Si City or Town	reet and No n, Stete)	umber or Rur	al Route Nun	nber,
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	To the within 7 To the comple	X	29b. Signeture end title of certifier	1/1			29	c. Licens	se number		2	9d. Date sig	gned (Month,	Day, Year)	
			Clerry	~ / Clu	n/E.	V		0	.C.M.	E.		Au	igust 2	21, 200	00
			30. Name and addrass of person who	completed cause of d	leath (Iter			Stre	et. R	alti	more, Ma	arvlar	d 2120	01	
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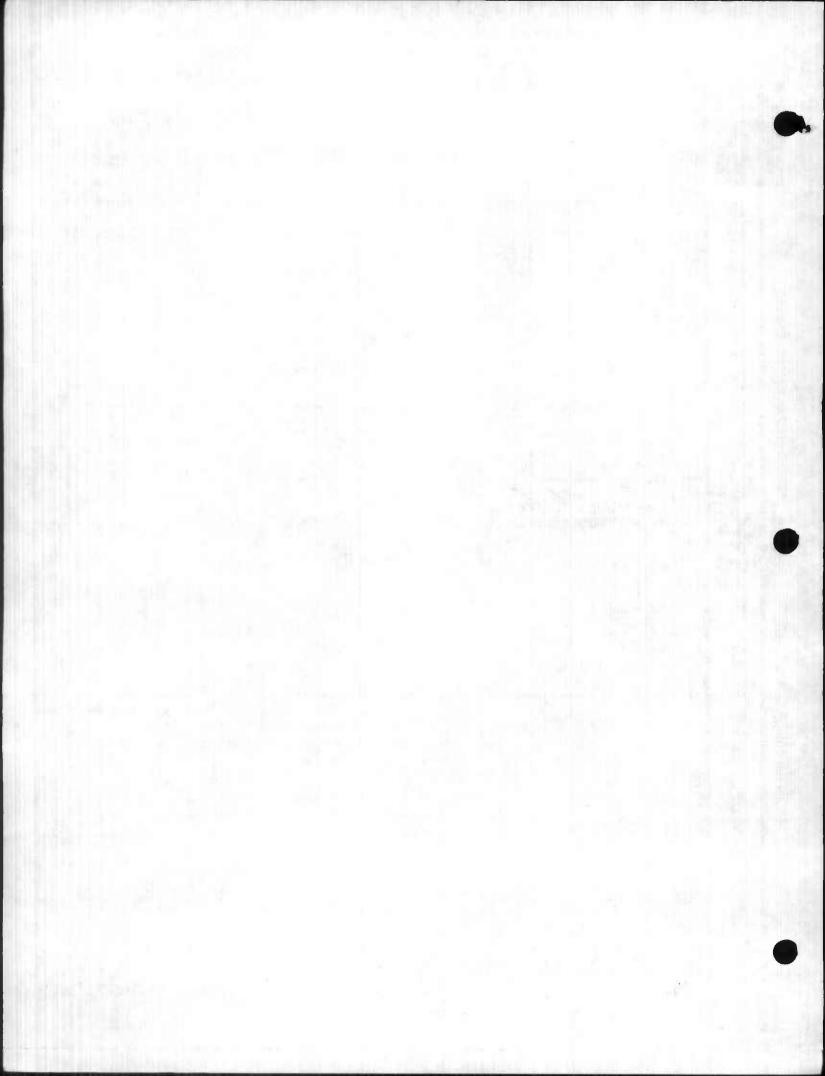
State Registrar



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				State of	iviaiyiaii		ertificate of				Reg. No.	0	26883
	HILL	1. Decedent's Name (Fit	rst, Middle, Las	1)						. Data of Dec	eth		3. Tima of Death
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	/Medical Examiner	4a Facility Nama (If not	institution, giva	street and num	iber)			4b. City, To		tion of Death			h
		Union Mer	morial	Hospi	tal			Balt	timor	:e	N.A	A	
3	Funeral	5. Social Security Number			7. Age (In yrs.	last birthde	Months Deys	If Under		Data of Birt (Month, De			hplace (State or Foreign untry)
	Director	218-07-73]M 2□F	83	Yrs.	Working Doys	1,0010	10000	06-16	5-17		MD
	g ,	Usual Residence of Dec	edent . County		100 Cit	y, Town or	ocation						10d. Inside City Limits
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	ter d	1 Never Merried	20 Marriad	Armed For	cas?		. Wes Decedent of if Yes, specify Cu	ban, Mexican	, Puerto Ri	can, atc.)	Bled	k, White	
)20	ors af			1 Yes If Yes, Give Yaar or Da	tas:		1 Yas 2 No	Specify:			Specify	Bla	ack
21215-0020			Decedent's Edu	cation		16a. Dec	edent's Usuel Occu	petion			16b. Kind of Bu		
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Maryland	sho and l	19e. Informant'a Neme/I	Raletionship (T)	ype, Print)		19b. Me	Iting Address (Stree	and Number	er or Rural I	Route Numbe	er, City or Town,	State, Z	(ip Code) 21213
	and alth	Linda Oli	iver J	ones		3823	Elmley	Ave	enue	Balti	more,	Mar	yland
ore	H Por Heart of He	20e. Method of Disposition		Damassal faces C		lece of Dispendence, cr	position (Name of emetory or other pl	ece)		Dete	20c. Location -	City or	Town, Stata
E	Page	4 Donetion 5	Other (Specify))	D	ruid	Ridge C	emete	ery 0	8-24-	-2000 F	ike	sville, MD
Baltimore,	T S S S S S S S S S S S S S S S S S S S	21, Signature of Funeral	Service Licens	00			22. Name end Add	ess of Facilit	у Ва	ltimo	ore, Ma	ryl	and 21202
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of Vital Records,	5 5 G									24a Was	en autopsy	24b	Were eutopsy findings
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3e	The law ite has beage 2 s												
<u>=</u>	Co Cate									101			1 ☐ Yes 2 ☐ No
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Division	9 # 5 E	4 Homicide	determined	buildin	g, etc. (Specifi	y)	straet, fectory, office	,	20	City or Tox		01 01 710	or route rombor,
	uneral Industrial all filled	29a. Certifier 1	Cartifying Phy	elcles: To the l	nest of my kno	wladna da	ath occurred at the	time data an	d otaca en	d due to the	causa(s) and me	annar se	estated
	T 2 L 2				sis of examina		investigetion, in my						
	within 2 To the comple	29b. Signeture and title of	of certifier				29c. Licer	se number			29d. Date signe	d (Mont	h, Dey, Year)
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		30. Neme and address o	f nerson who o	ompleted ceuss	of death (Item	23e) (Tun		0 5 2 -) (1 49051	1	1,2000
		Mack Lavi	5 0	13 AMON	L C N	C O P	ine ila	in M	naman	al Hisa	ital Ba	Him	9, 2000 ore, Maryland
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Dr



Piease Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Pridgen 11:20am Whitehead Jeanette 2000 22, Aug /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner NA Baltimore Gilchrist Nursing Center if Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) TT Dele of Birth (Month, Day, Year) 10-23-63 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□ M 25 F VA Yrs Director 36 216-78-1402 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show event, the Medical Examiner must be notified at NEWes 2□No Directo Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 Funeral 1126 Halstead Road 14. Rece · American indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 € No If Yes, Give 8 1 Never Married 2 Married 1 Yes 2 No Specify: Black λq 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16b. Kind of Business/Industry Schools 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Substitute Teacher 8th Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 1 end 2 should be Health and Mental Lewis Lizzie Whitehead, Sr. marked Tommie 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1234 1126 Halstead Road Baltimore, Maryland 19e. Informent's Name/Reletionship (Type, Print) . of Health at the Health at Health at 17 Health at 17 Health at 17 Health at 18 Heal Pridgen Alton 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 1 Buriai 2 ☐ Cremation 3 ☐ Removel from Stete permit. Pege Department of Important: If any Injury or once. Mt.Zion Cemetery 08-25-2000 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 1. Enter the disease, or complications that c. t., if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on a Approximate Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition resolting in death) /Medical unth Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of) the Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 20 No 3 Probably 4 Unknown by 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Medical Certification: To 03 this 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending 1 Natural after death. Director: Af 1 Yes 2 No 2 Accident investigetion 3 Suicide 6 Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signatury 29c. License number 29d. Date signed (Month, Day, Year) mus)

Registrar

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Maryland

Baltimore,

requires that the death certificate be executed

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or Attending Physician:

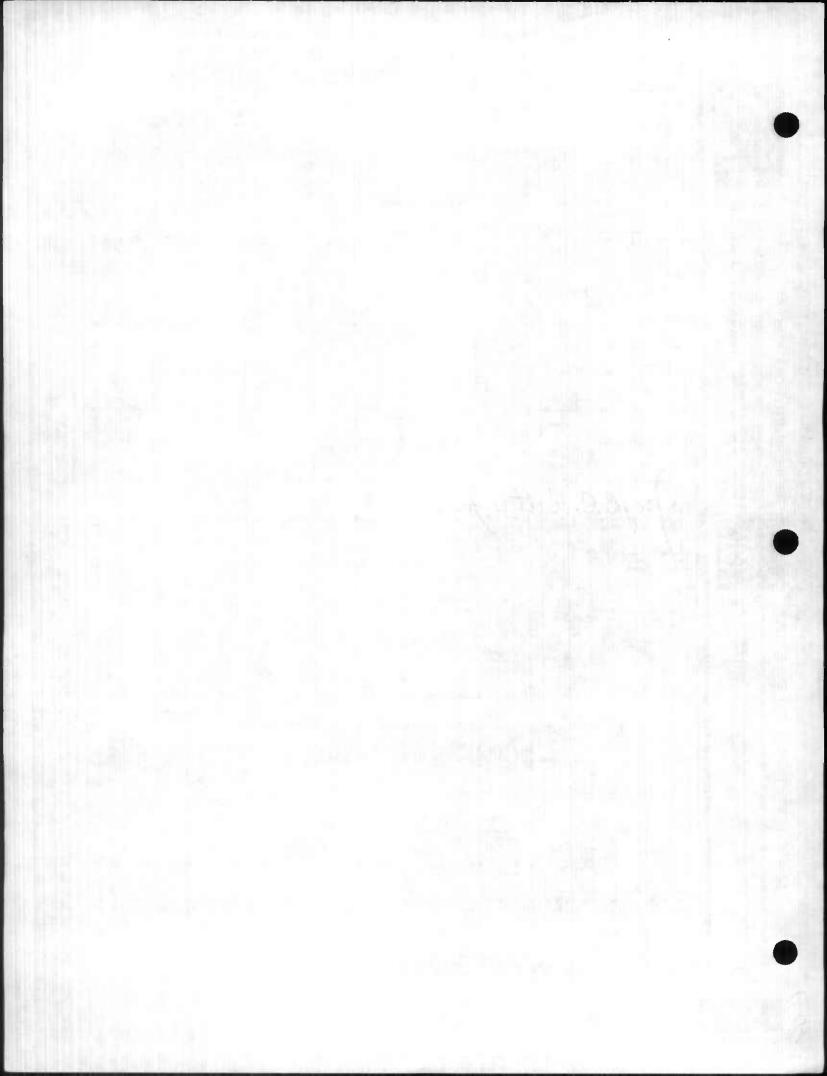
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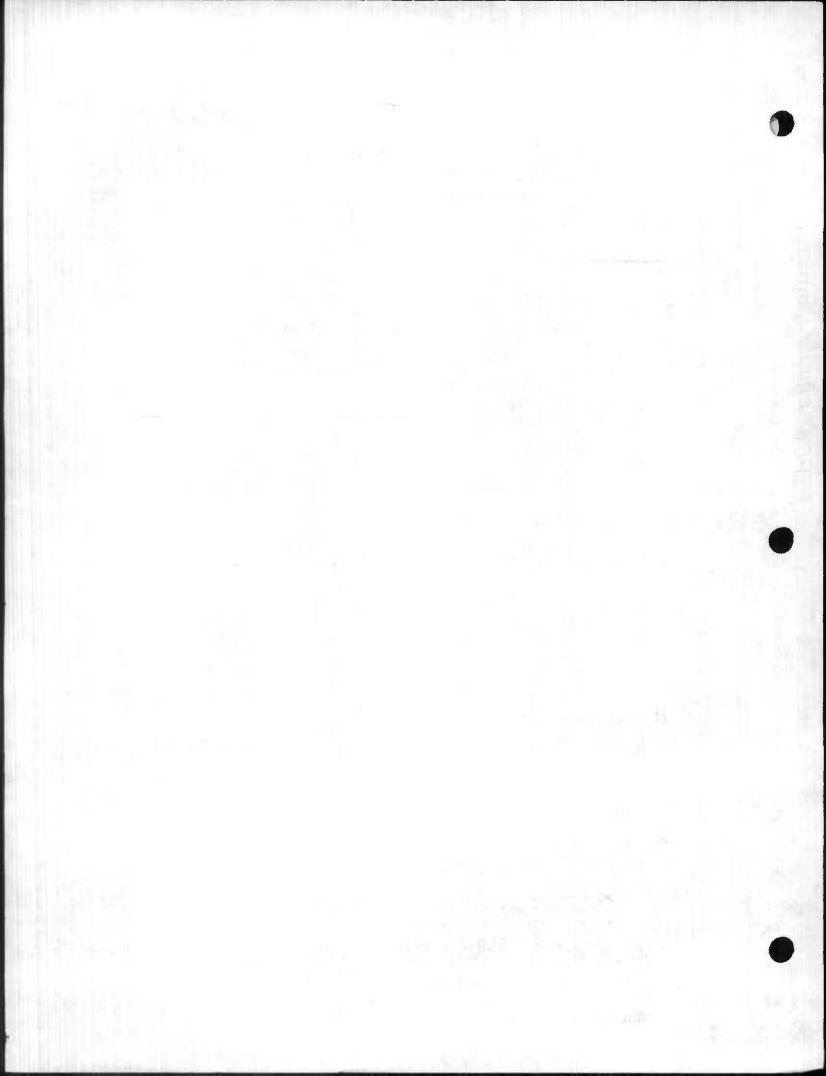
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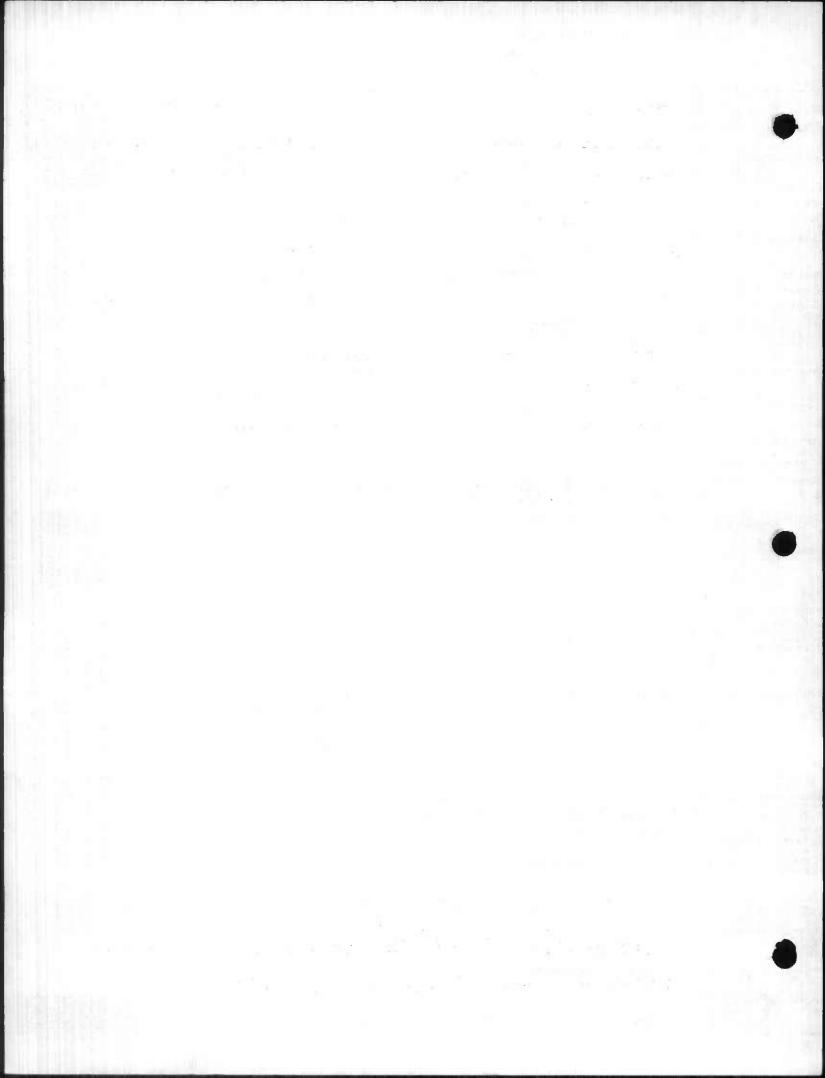


AN	TENDED TIEM	Stat S 10e,19b PER FH G786 8/24/0	e of Maryland / De	partment of He ertificate of D		Reg. No.	26885
	Physician	Decedent's Name (First, Middle, Last)			Mon		3. Time of Death Year 9: 445 DM
	/Medical Examiner	MARTIN MEYER 4a Facility Name (If not institution, give street as		POMERANTZ 4b	. City, Town, or Location of		DOO 1-73 PF
		Sinai Hospital	of Baltim	re	Baltimore	N,	
	Funeral Director	5. Social Security Number 10-01-8131 6. Sex 110-01-8131 12-M 20	7. Age (In yrs. last birthda	Months Davs	Hours Min. 8. Date (Mon	of Birth th, Day, Year) 15 1915	9. Birthplace (State or Foreign Country) BRONX, NY.
	oth the Maryland or 28a-1 show be notified at Director	10a. State 10b. County BALTIMORE	10c. City, Town or BALTI		V		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	in with the Ma 23s or 28s-f s unt be notified al Director	10e. Street and Number POINSETTIA 4 POINSETTA COURT		10f. Zip Code 21209		10g. Citizen of W	hat Country?
	r hams 2 diner mus Funers	11. Marital Status 12. Was	Decedent Ever in U.S. 1 ed Forces?	3. Was Decedent of His	panic Origin? (Specify Yes , Mexican, Puerto Rican, et	or No- 14. Raca	- American Indian, , White, etc.
020	D	1 Never Married 2 Married 1 N	Yes 2 No es, Give or or Dates:	1 ☐ Yes 🏋No	Specify:		WHITE
5-0	72 ho matur dical eted	15. Decedent's Education (Specify only highest grade comple	eted) 16a. De	cedent's Usual Occupative kind of work done due. DO NOT use retired)	lion Iring most of working	16b. Kind of Bus	siness/Industry
21215-0020	ed within 72 ho rgient. we than "naturn it, the Medical. Completed	Elementary/Secondary (0-12) Colle	ege (1-4or 5+) OWNE			TRANSPOR	RTATION
Maryland	Mental Hy write outh write event	17. Father's Name (First, Middle, Last) DAVID	POMERANTZ		18. Mother's Name (First, A LENA	Middle, Maiden Sumame BIELER)
Mary	nd 2 shot db and 3 27 is man r traumm	19e. Informent's Neme/Reletionship (Type, Print) DR. DIANE POMERANTZ/DA	UGHTER 4 P		nd Number or Rural Route OURT BALTIMOR		Stata, Zip Code)
altimore,	egos 1 a nrt of Hea t: If Hear y or othe	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Discemetery, of	sposition (Name of cremetory or other place I CONGREGAT			City or Town, State
Baltir	Departmi Departmi Importan any injur	21. Signature of Fund at SerVice License		22. Name and Address	s of Facility SOL LE	EVINSON & BI	ROS. INC.
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one ceuse	that caused the death. Do not	900 REISTER	RSTOWN ROAD F	PIKESVILLE,	Approximete
-61	Physician /Medical Examiner		Due to g as a con	A 1	Disease		Interval Between Onset and Death
	executed in and ital-transit	b	Adult on	et DM			
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687	the the	that initiated events resulting in death) Lest	Due to (or as a cons	sequenca of):			
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Re	certificate has rector, page 2 Be Comp					1□ Yes 2 No	1 ☐ Yes 200 No
/ital	certifica rector, p	25. Was case referred to medical axaminer?			26. Place of Death (Check	only one)	
of V	His P	1 ☐ Yes No Hospital:	inpatient 2 ER/Outpa		4 Nursing Home 5L		1 1 21
-C	After Fune	2 ☐ Accident investigetion	Date of Injury (Month, Dey Year) 28b. Tim- Injur	ry Work	at 28d. Des	scribe how injury occurre	ed .
Divis	s after de la Direct ed in by t	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, ferm, building, etc. (Specify)	street, factory, office		ation (Street and Number or Town, Stete)	er or Rural Route Number,
	To the Hospital or Attending within 24 hours after death of the Funeral Director. After completely filled in by the fune Medical Certification	(Check only 2 Medicat Examiner: On	o the best of my knowledge, de the basis of examination and/or manner stated.	eath occurred at the time r Investigation, in my op	e, date and place, and due inion, deeth occurred at the	to the ceuse(s) and men time, dete and place, a	nner as stated. and due to the cause(s)
	To the Comp	29b. Signature and title of certifier	TA: 12	29c. License			(Month, Day, Year)
	,0	30. Name and address of person who completed	Cause of death (from 23a) (Tim	D RE	s 000 altimore,	August	19, 2000
		Henry Tan. 2401 We		Ave, Bo	iltimore,	MD 2121	5
	State Registrar	31. Date filed (Month, Day, Year) AUG 2 4 2000	33x Registrar's Signature	Sparks			



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للتحيير						Cei	rtificate of	Death		Reg. No.	0 20	000
Physic	ian	1. Decedent's Name (First, Mi	ddle, La	st)	172				2. Date of D Month	Day	Year 3.	Time of Death
/Med		CLYDE C. RA						-	08		00	1145
Exam	iner	4e. Facility Neme (If not institu							or Location of Dee		ty of Deeth	
Francis		Homewood at 5. Social Security Number	6.5	ex 7	Age (In yrs. I	est birthday)	If Under 1 Yea	William			hington	(State or Foreign
Funera Directo		214-09-0323 Usuai Residence of Decedent	1	M M 2□F	95	Yrs.	Months Days	Hours M	Feb 1	irth Pay, Year) 9, 1905	Country)	(oratio or 7 oronger
rland		10a. Stete 10b. Cou	nty		10c. City	, Town or Lo	ocation				10d. i	nside City Limits
Meny	tor	MD Wash	ing	ton		Willia	amsport				1	☐ Yes 2Ã No
th with the 23a or 28	Funeral Director	10e. Street end Number 16505 Virgini	a A	venue			10f. Zlp Code	21795		10g. Citizen o US	f What Country? A	
d 21215-0020 filed within 72 hours after death with the Meryland thygiene. ther than "naturel", or items 23s or 28s-f show not, the Mexical Examera must be inclined at	by	11. Marital Status 1 Never Married 2 N 3 X Widowed 4 Divorce		12. Wes Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ☑ No	'	Was Decedeni of If Yes, specify Cul 1 ☐ Yes 2 ☒ No		(Specify Yes or Nerto Rican, etc.)		ace - American in ack, White, etc. White	
72 h	Completed	15. Deced (Specify only hig	lent's Ed	ducation ide completed)		(Give	dent's Usual Occu kind of work done	during most of i	vorking	16b. Kind of	Business/Industr	у
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re, Maryland 2 s 1 and 2 should be filed f Heelth end Mentel Hygi tem 27 is marked other other traumatic event, I	To Be	Adam R. Raff							Hester 1		3013	
Should Man	-	19a. informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Stree	t and Number or	Rural Route Num		n, State, Zip Cod	(e)
My and 2 selth e		Donald Raff/s	on			128	Trinidad	Street	Naples,	FL 34	113	
0 90- 2		20a. Method of Disposition 1 Burial 2 Cremetic 4 Donation 5 Other			~	aca of Dispo	osition (Name of metory or other pla		Date		- City or Town,	State
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ysicien: The	Be	25. Wes case referred to medi examiner?	cal	Hospitai:				thor. A	Death (Check only			
- 5 00	ation: To	1 Yes 2 No 27. Manner of Deeth 1 Netural 5 Pen 2 Accident	ding stigation	1 □ tnp 28a. Dete of i (Month,		ER/Outpation 28b. Time of Injury	28c. Inju	4V2SQVursing	Home 5 Res	how Injury occ		
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homlcide dete	ld not be mined	289. Piece of	Injury - At hor etc. (Specify	me, farm, str	eet, fectory, office		26f. Location City or To	(Street and Num own, Stete)	n <i>ber or Rural R</i> oo	ite Number,
To the Hospital or within 24 hours efter	edical	29a. Certifier tt Certification (Check only one)	ying Ph ai Exam	ysician: To the be ninar: On the basis and manner	s of examinati	riedge, death on and/or inv	occurred at the t vestigation, in my	lme, date and pla opinion, death oc	ice, and due to the curred at the time	e cause(s) and r , date and place	nanner as stated t, and due to the	cause(s)
To I To I	M	29b. Signeture end title of certification with the second		m, ass	War	42/	/	se number	40	29d. Date sign	led (Mogth, Day,	Year)
M.	4		en	completed cause of	of death (Item			(D) 3'	1742			
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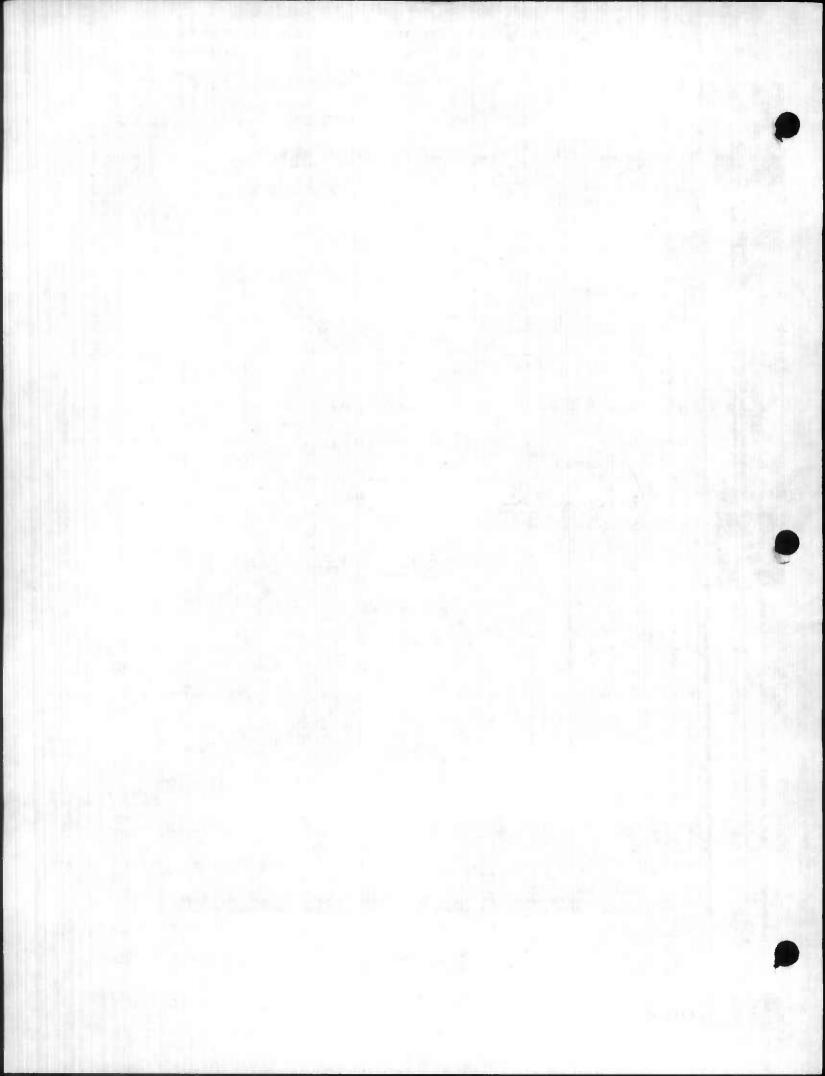


State of Maryland / Department of Health and Mental Hygiene

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	Certificate	of Death		Reg. No.	
hysician	Decedent's Name (First, Middle, Last)		2. Dete of De Month	Day Yea	3. Time of Death
/Medical	PEARL SMITH		AUGUST		2:10pm
xaminer	4a Facility Name (If not institution, give street and number) MARINER HEALTH @ NORTH ARUNDEL	4b. City, Town, or GLEN BURN		4c. County of De	
neral ector	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months 70 Yrs.	Year If Under 24 Hrs. Deys Hours Min.	8. Date of Bird (Month, Da 6-5-1	1h 9. 8 9. 8	irthplace (State or Fore Country) MD •
	Usuel Residence of Decedent				1404 1-14-07-11-1
nouned at	MD. ANNE ARUNDEL SEVERN				10d. Inside City Limi
0 4 0	10e. Street and Number 10f. Zip C 8034 CLARK STATION RD. 21	ode 144		10g. Citizen of What 0	Country?
Ther must		nt of Hispenic Origin? (S y Cuban, Mexican, Puerl	pecify Yes or No		nerican Indian,
b P	1 Never Merried 2 Married 1 Yes 2 No If Yes, Give A Year or Detes:			Spacific	BLACK
natural parties	life DO NOT use	done during most of wor	rking	16b. Kind of Busines	s/Industry
other than "naturn vant, me Medical Se Completed	Elementary/Secondary (0-12) College (1-4or 5+) PROCESSI			SOCIAL S	ECURITY
To Be C	17. Father's Neme (First, Middle, Last) ISAAC WILSON	18. Mother's Nar		, Maiden Sumeme)	
5		Street and Number or Re			
other tr	20a. Method of Disposition 20b. Plece of Disposition (Neme	K STATION R	D. SEVER	N. MARYLAN 20c. Location - City	
ury or	1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, cremetory or oth ST. JOHN AME Z	er plece)	-24-2000	ODENTON,	
any in		Address of Fecility WM TST. ANNAP		& SONS MOR	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.				Approximate Intervel Between
attending physician and I for use as the burial-transit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or as a consequence of):	lellit	20		
be detached for u	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23b. Dld	tobacco use contribu	ite to the cause of dea
detached	MultiInEast Dement			. /	Probably 4 Unkn
should be de	10011170101010		24a. Was	en autopsy 24l	b. Were eutopsy finding
Completed			pont	Similad:	completion of cause of death?
rector, page 2	St. Western description of the second state of			Yes 2110	1 Yes 2 No
irector.	25. Wes case referred to medical examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA	Other	ath (Check only o		neoiful
e funeral dire		c. Injury et Work? 1 Yes 2 No	·	denca 6 Other (S)	oechy)
in by th	3 Suicide 4 Homicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, building, etc. (Specify)	offica		(Street end Number or wn, Stete)	Rural Route Number,
completely filled Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred el complete and menner steted.				
Me Me	29b. Signeture and title of certifier 29c.	License number		29d. Date signed (Mo	onth, Day, Year)
/	Malus B Krapulan.	014753	3	8/23/	00
5	30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)	Vorville	Mru	nland	21208
State	31, Date filed (Month, Day, Year) 32. Registrer's Signeture	· m la Cold	1,100	June	100
egistrar	AUG & 4 2000 General & Spark				

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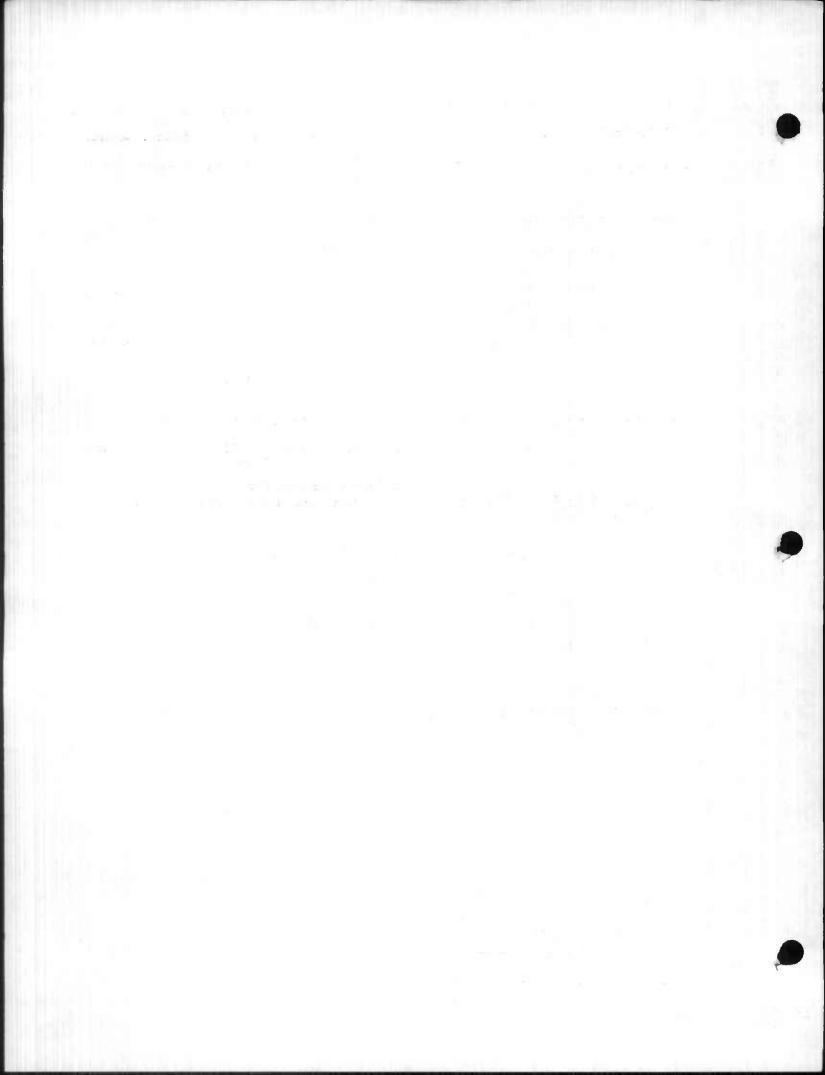


State Registrar 31. Date filed (Month, Dey, Year)
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32. Registrar's Signature

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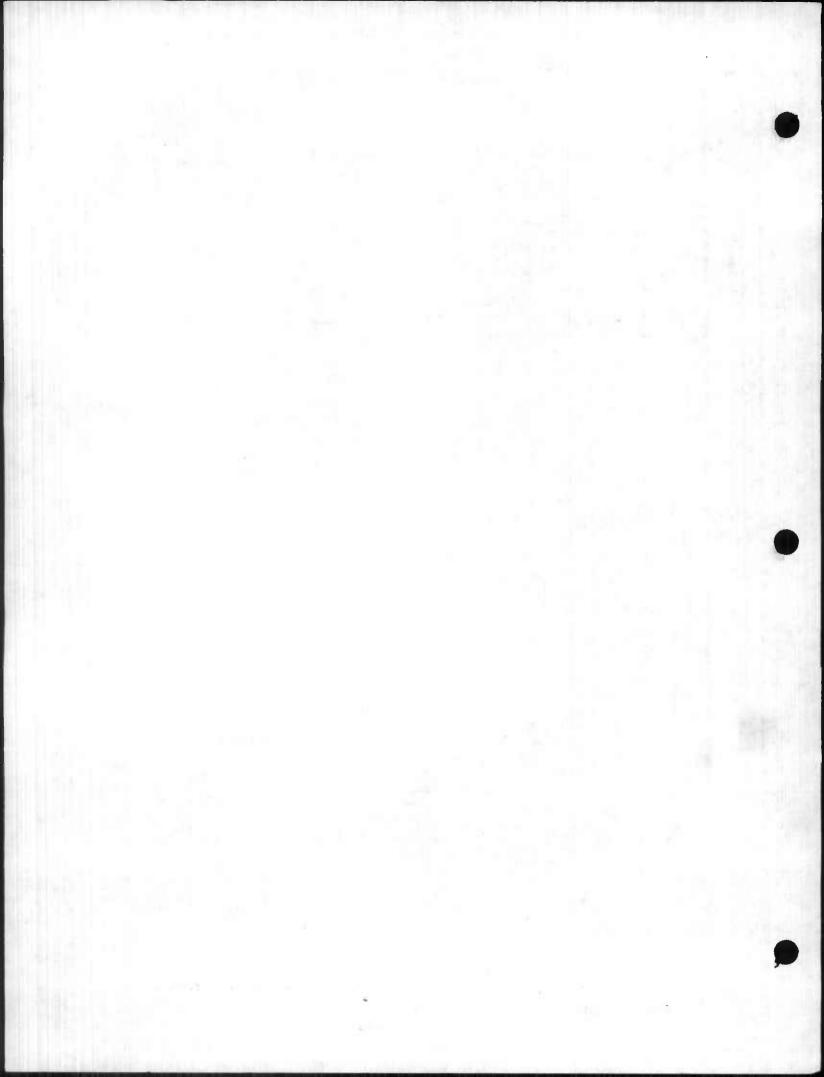
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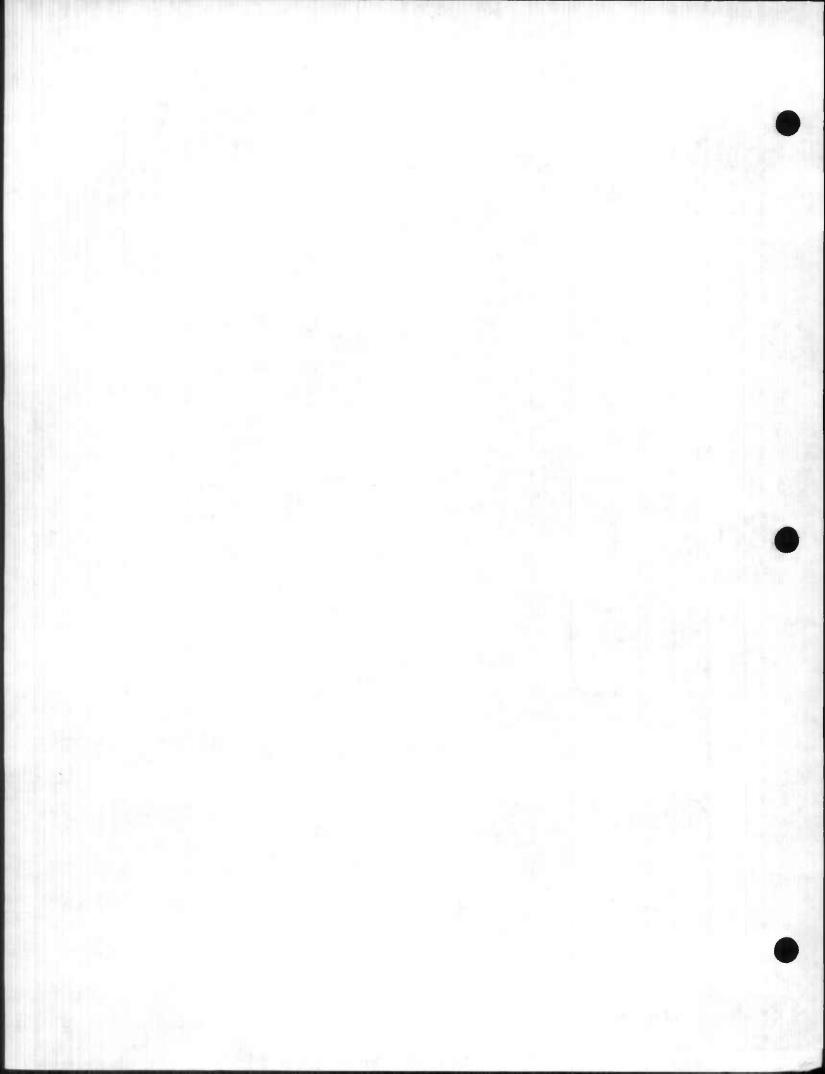
Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. 00-4602-005 State of Maryland / Department of Health and Mental Hygiene MARIE E. SKIPPER Certificate of Death 28A-F PER MEO G787 9-6-00 WR. AMEND ITEMS: #23 PART I,27 00-4605-005 Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death **Physician** Marie Н. Skipper 15, 2000 AUGUST 10:00 P.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13726 HILTNER ROAD BALTIMORE REisterstown If Undar 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 XF 213-40-6945 58 Yrs. July 16,1942 Director Washington DC Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Maryland Reisterstown Directo 10g. Citizan of What Country? 10e. Street and Number 10f. Zin Code 21136 United States 13726 Hiltner Road 238 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. or items 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Giva Yaer or Detes: 1 Nevar Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify specify: White py 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) Legal Secretery Lawyer permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygi Important: If Itam 27 is marked any Injury or other to page. 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) William Edward Hallam Elsie Mae Kehne 19a, Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David William Skipper/Stepson 320 Leyton Road Reisterstown, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State Chesapeake Crematory, Inc. 8/23/00 Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 21. Signeture # Funerel Service Licensee 8717 Green Pastures Drive, Baltimore, MD mura (- flandasty 21286 Approximate Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ACUTE AMITRIPTYLINE INTOXICATION Examiner Due to (or es e consequence of) Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioled events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical Dua to (or as a consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has 1 Tres 2 No 1 Tes 2 No certificata or Attanding Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 10ther (Specify) 0 1 XYes 2 No this (P 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury et Work? After Found:M 1 Neturel 5 Pending investigation after death.

Director: After in by the furnitudes of the furnitude of th Found: Found: M 10
8-15-00 Found: M 10
28e. Pleas of Injury - At home, term, street, fectory, office building, etc. (Specify) SUBJECT INGESTED DRUG 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number, or Bural Route Number, RD City or Town, State) 137 HILTNER RD 4 Homicide BALTIMORE COUNTY, MD RESIDENCE within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. AUGUST 16,2000 huten 30. Name and address of person the completed causa of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ennis Lnutera 31. Dete filed (Month, Day, Year) AUG 2 4 2000 32. Registrar's Signeture State Registra



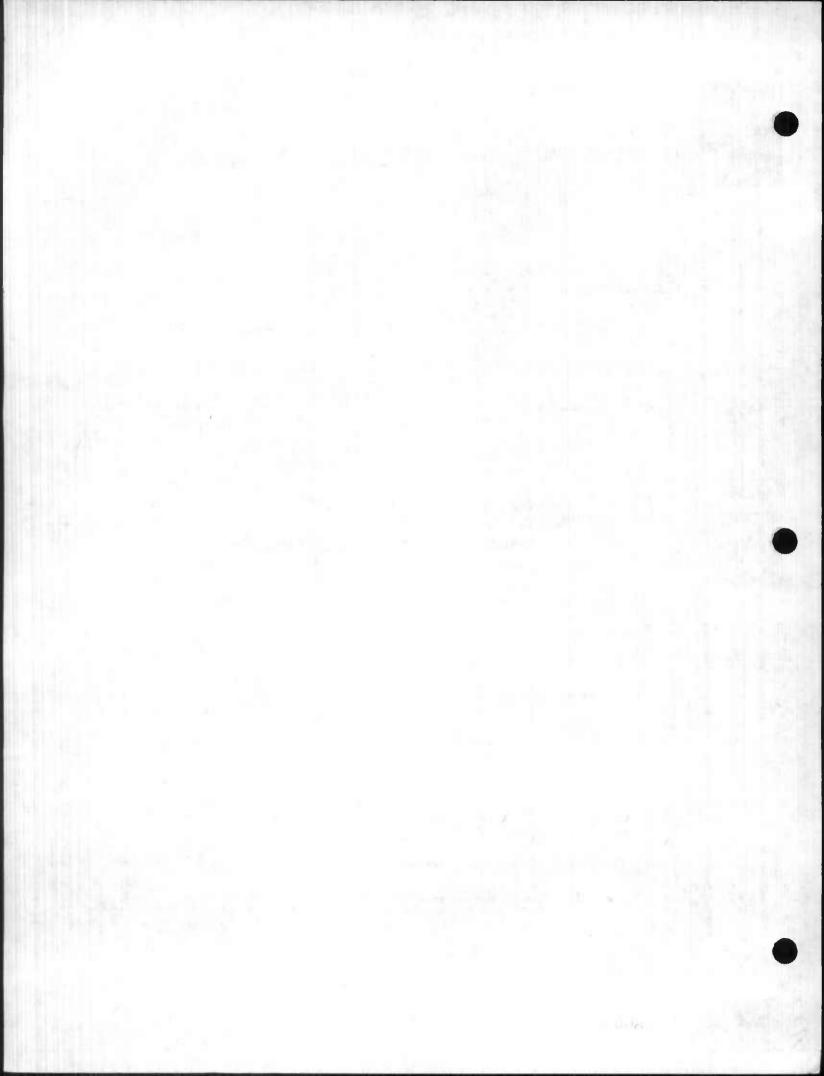
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	DICINS HOS	Spital	Baltimos Year I II Under 24 Hrs.	8. Dete of Birth	N/A	
	\$ex 7. Age (In yrs. Ia 1 ★ M 2 □ F 49		Deys Hours Min.	(Month, Day, August 2	Year) 3, 1950 P	Birthplace (State or Fore Country) ennsylvania
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Pennsylvania Daur	phin]	Harrisburg	ode	1	Dg. Citizen of Wha	Λ
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3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2		Hican, etc.)	Specify: W	Vhite, etc. Thite
15. Decedent's E (Specify only highest gro	ducation rade completed)	16a. Decedent's Usual C	done during most of work		16b. Kind of Busine	
15. Decedent a E (Specify only highest gr. Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)		Desire	tina
	4 years	Printing S	18. Mother's Nem	e (First. Middle A		ting
William C. Stout			Frances		Cast	or
19a. Informent's Name/Relationship		19b. Mailing Address (S	Street and Number or Rur			
Carolyn W. Stouf			ney St. Harr			
20e. Method of Disposition	20b. Pla	ace of Disposition (Neme	of	- India	20c. Location - City	
1 Buriei 2 Cremetion 3 5 4 Donation 5 Other (Special	Hemoval from State	ver Funeral	Home & 8	-22-00	Harrisbu	rg, Pennsyl
21. Signeture of Funeral Service Lice	insee	22. Name and A	Crematory Address of Facility Ll-Wiedefeld			
George F	enanne	6500	York Road	Baltimor	e. Marvl	and 21212
23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplicetions that caused the death. y one cause on each line.	. Do not enter the mode of	of dying, such es cardiac	or respiratory arr	est,	Approximete Interval Between Onset and Deetl
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State of Maryland / Department of Health and Mental Hygiene

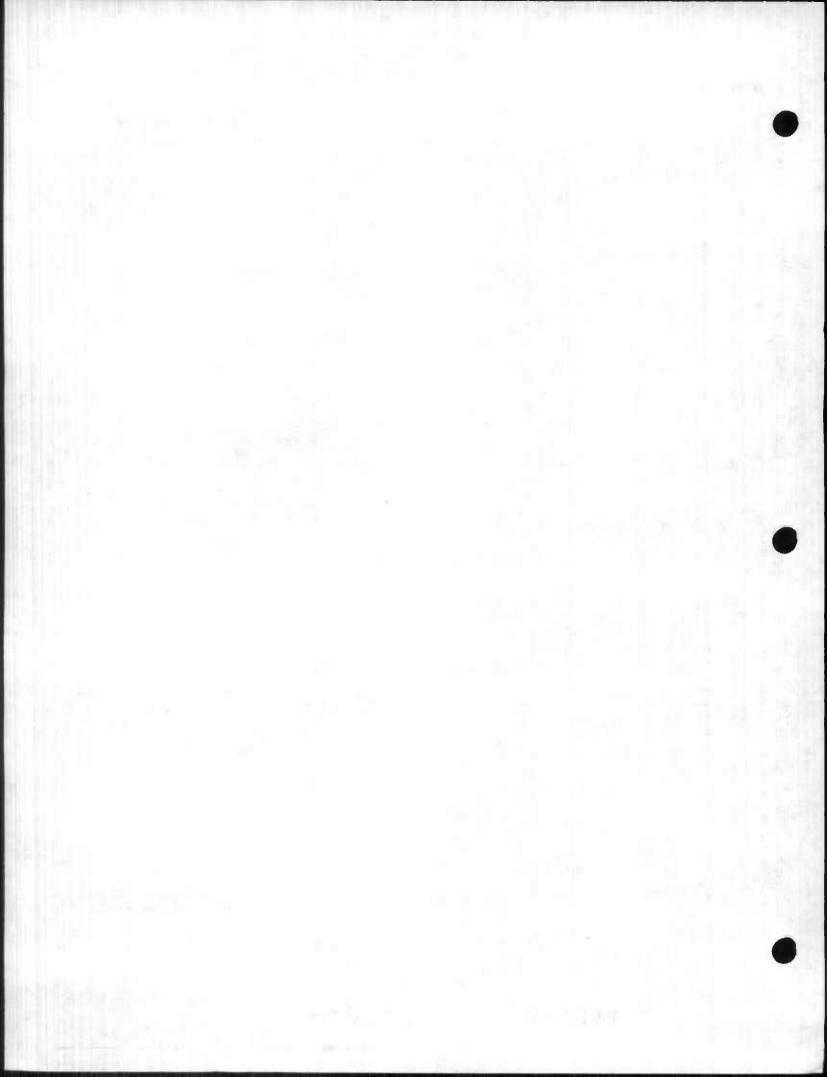
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/Medical	Patricia 4a Facility Name (If not institution, give		Sabatino	4b. City, Town,	or Location of Death	-	2000 3:25 PM
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our after death value, or thems 234 Examiner must	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		dent of Hispanic Origin? cify Cuban, Mexican, Pu 2 (X)No Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race Black Specify:	- American Indian, ; White, etc. White
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Mental to the state of the stat	Robert Fra	ank Hirt		Li	llian	Adele	Kosojet
nd 2 sto allth and 27 is my r traum	19a. Informant's Name/Relationship (7) Joseph M. Sabatino			(Street and Number or lale Avenue		ore, Mar	
emit. Pages 1 a apparament of Has reportant: If them my injury or other frice.	20a. Method of Disposition 1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		Place of Disposition (Nancemetery, crematory or of t. Joseph C		8-26-00		city or Town, State rton, Maryland
Depart Depart Imports any ink	21. Signature of Funeral Service Licens	Entered Le		d Address of Facility	Baltimore	e, Maryla	
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only c		th. Do not enter the mod	le of dying, such as card	fiac or respiratory a	rrest,	Approximate interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	SINGE IV	NON-SMALL	CELL LUN	G CANCE	₹	1½ YEARS
	resulting in death)	Due to (or as a consequence of):				
cate be executed physician and s the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or es a consequence of):				
entificate be executing physician and as the burial-transfer AMedical Exar	resulting in death) Last	Due to (d	or as a consequence of):				
death cert a attendin d for usa	Part II. Other significant conditions co	otribution to death but not re-	sulting in the underlying o	ause given in Part I	23b Dld	tobacco usa con	tribute to the cause of death
es that the death certigned by the attending be detached for use by Physician/M		involing to dollar but not to	naming in the arrostrying o				3 Probably 4 Unknow
been s should			<u> 1872.</u>		24a. Was perfo	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
ysician: The lav s certificate hes director, page 2	S 7.96				10	Yes 2 No	1 □ Yes 2 No
clan: entific ector,	25. Was case referred to medical examiner?	15.59.1			Deeth (Check only	one)	
Physician: this cartific ral director.	1 ☐ Yes 2 No 27. Menner of Death		ER/Outpatient 3 DC		g Home 5 Resi	dence 6 Othe	
ding h. After funer	1 Neturel 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe	now injury occurr	90
tal or Attending Prise after death. al Director: After ted in by the funeration: Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory		28f. Location (City or To	Street end Numbe wn, Stete)	er or Rural Route Number,
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of Medical Certification: T		sicien: To the best of my kno ner: On the basis of examina and manner stated.					
To the comp	29b. Signature and title of certifier		973	c. License number		29d. Date signed	(Month, Day, Year)
	1 nativida	d Di de Se	on mest	19508		8/23	100
		ompleted cause of death (Item	-	ER DRIVE	TOWSON,	MARYLA	ND 21204
State Registrar	31. Date filed (Month, Day, Year) AUG 2 4 200	32. Hagistrar's Sign	ature & Ap	arks			

ORIGINAL

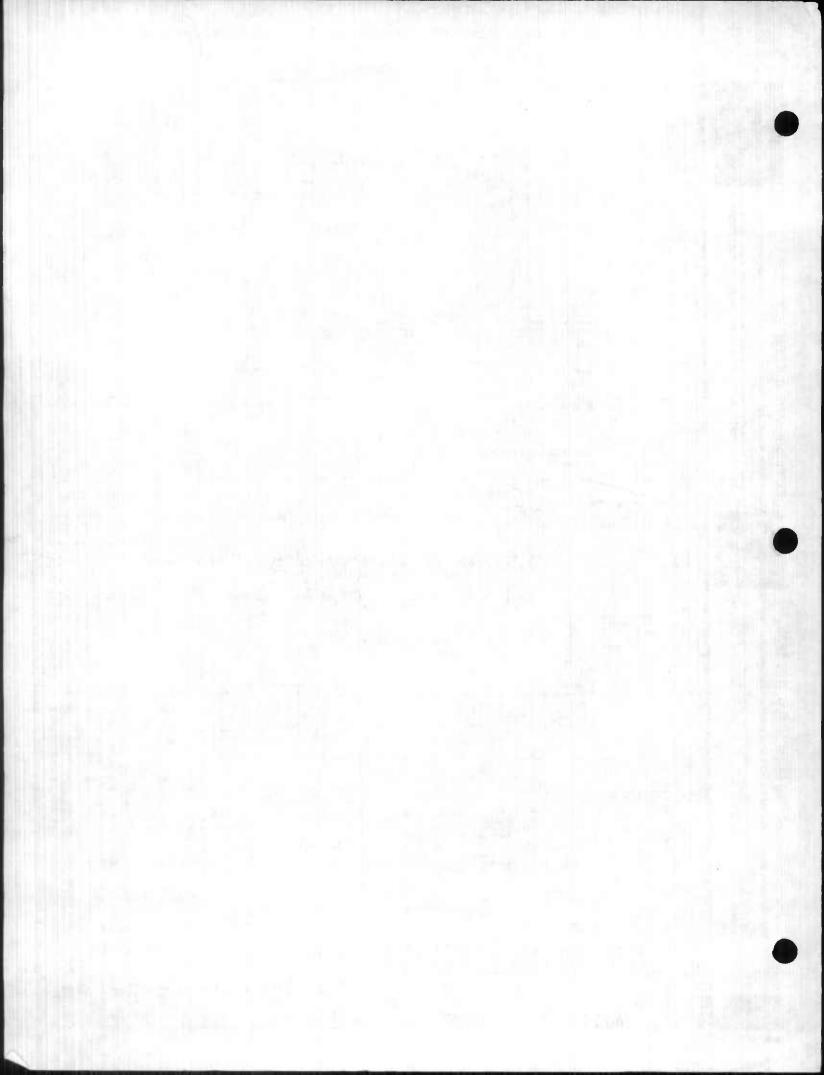


State of Maryland / Department of Health and Mental Hygiene 00 26892

ysician Medical	1. Decedent'a Nar	4000 4 5 5 5 6						te of				Reg. No.			
		ne (First, Middle	e, Last)								2. Date of D	eath Day	Yaar		a of Death
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aminer	4a Facility Nama	(If not institution	n, giva str	eet and numbe	r)				4b. City, To	wn, or L	ocation of Dea		nty of Death	1	1-11
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al	5. Social Security	Number	6. Sex	7. 4	Aga (In yrs. i	last birthday)		r 1 Year				rth	9. Birtt	place (St	ate or Fore
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	10a. State	10b. County			10c. City	y, Town or Lo	ocation							10d. Insid	le City Lim
tor	MD		N/A			BALTI	MORE							1 🔀	Yas 201
Directo	10e. Street and No	umber						p Code				10g. Citizen	of What Co	untry?	
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2		rried 2 Marr	ried	Armed Forces							Rican, etc.)	В	lack, White	, etc.	
ŀ		4 Divorced		If Yes, Give 7 Year or Dates	7		1 Yas	2 No	Specify:			Spe	cify:	WHITE	
		15. Deceden	t's Educat	ion		16a. Dece	dent's Us	ual Occup	pation			16b. Kind of	Business/I	ndustry	
į		cify only higher		omplated)		(Give	kind of w	ork done	during mos	t of work	ring				
Completed	Elementary/Sec	condary (0-12)		College (1-4o	r 5+)	HOMEM	AKER					OMN	HOME		
1	17. Father's Name	(First, Middla.	Last)			11011111	II II (L)I (18. Moth	er's Nam	e (First, Middle	, Maiden Sum			
o Be	JULIU		s.		,	OBERMA	NT		BESS					ERMAN	,
-				D.L.O.	<u> </u>			- (D)			- I Davida Moral	China Fa			
	19a. Informant'a											ber, City or Tox		ip C000)	
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	20a. Method of Di	Sposition	3 □Ren	noval from Stat	C	emetery, cre	matory or	other ple	ce)		Date	20c. Locatio	n - City or	own, Sta	10
		5 Other (S				I ISRA	AEL C	EMET	ERY	18	3/23/00	BALTI	MORE,	MD	
S .	21. Signaturarul F	uneral Service	Ocensee	0	4	2:	2. Name a	ind Addre	ess of Facili	ty	SOL L	EVINSO	T C DI	200	TNIC
me ounar-transminer					Dun to la	y ein	3 67 C	1.					t i	10	
edicai Examiner	Sequentially list c if any, leading to cause. Enter Und Cause (Disease of that Initiated even reaulting in death)	immediate lerlying or Injury ts	b		Due to (or	ras a consecuta as a	quence of):					1	10	
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	OO EW		Ce	rtificate of	Death	1	Reg. No.	JU	2009
Decedent's Name (First, Middle, La EVELYN				SHIPLEY		2. Date of De Month	Day	Year	3. Time of De
I BYEBER	S.			SUIPLEI	4b. City, Town, or	AUGUST	13, 20		8;45 pm
4a Facility Name (If not institution, give		98)			PASA:			y of Death NE ARI	INDET.
7938 SHIPLEY ROAL 5. Social Security Number 6.5		Age (In yrs. la	last birthday)	If Undar 1 Yaa					piace (State or Fe
217-46-4261	10M 20F	91	Yrs.	Months Days	Hours Min.		y, Year) 6. 1909	Coui	RYLAND
Usual Residence of Decedent				1		THENCH	0, 100		
10a. Stata 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City t 1 ☐ Yes 2
MARYLAND ANNE AS	RUNDEL		I	PASADENA					
10e. Street and Number 7938 SHIPLEY ROAI	n			10f. Zip Code	1122		10g. Citizen of		ntry?
11. Marital Status	12. Was Deceder	nt Ever in I ! S	S 13			pecify Yes or No	U.S.A		can Indian,
1 Never Married 2 Married	Armed Forces	s? ANo			Hispanic Origin? (S ban, Mexicen, Puar	o Rican, etc.)		eck, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Datas			1□ Yes 2☐ No	Specify:		Speci	WHI?	re
15. Decedent's E (Specify only highest gro			16a. Dece	dent's Usual Occu	petion a during most of wo	rkina	16b. Kind of I	Business/In	dustry
Elementery/Secondary (0-12)	College (1-40	or 5+)			e during most of wo				
Elementery/Secondary (0-12) 5	e)		HAT	MAKER	18. Mother's Na	na /Firet Middle		FACTO	DRY
17. Fathar'a Name (First, Middla, Last JOHN	C.	WOOD			MARY	ne (r rrat, Milodie)	MARI		
19a. Informant's Name/Relationship			19b. Maiti	ing Address (Street	et and Number or Ri	ural Route Numb			p Code)
MR. JOHN SHIPLEY	(SON)				N DRIVE,				
20a. Method of Disposition		Ce	lace of Dispo	osition (Name of matory or other pl	ece)	08/17/20	20c. Location	- City or To	own, State
1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Speci		ta		EN MEMOR:		00/1//20	GLEN BU		
21. Signatura of Funaral Sauce Lice					ress of Facility SI	NGLETON			,
1/-//					AVENUE, S				
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diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last	a. Pro b. [Sc	Due to (or	le	quence of):	wary		on bo	212	Interval Betwe
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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death Month Day Yaer **Physician** LEROY TAYLOR MA 81:00 8 20 00 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Street Comet If Under 1 Yaar If Under 24 Hrs. B. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthdey) Birthpleca (State or Foreign Country) **Funeral** 111-32-986 63 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore 1 Pas 2 No Directo 28a-t 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Rems 23a or 1018 Comet Street USA 20212 Funeral 12. Was-Decedent Evar in U,S. Armed Forces? 1 ☑/fes 2 □ No If Yes, Give Yaar or Datas: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) pormit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien, Important; if hem 27 is marrised other the any Injury or other two Warehouse Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Riley Johnson Mariorie 1 aylor 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stefe, Zip Code) Johnnetta Zanatt / Daughter 5 237A Broadway Ave Eielson Air Force Esse Aksky 99102 20b. Piace of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Suriel 2 Cremation 3 Removal from State Voshell Memoran Curren 8-26-200 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Funeral Service, P.A. 709 Tessier St., Bult. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in deeth) /Medical Cardiovancular Disease. Examiner Due to (or as e consequence of): Examiner Atheros derose physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 2 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown bengis Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital al or Attending Physician: The safer death.

M Director: After this certificated in by the funeral director, pa 25. Was casa referred to medicel axeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Yes 2 No Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Netural 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, deta end place, and dua to the ceuse(s) and manner stated. 29a. Certifier

State Registrar DHMH 16 Ray 6/95

31. Data filed (Morting Dex Year) 2000

alsens

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifiar

PALACIOS MR 32. Registrer's Signature

HD

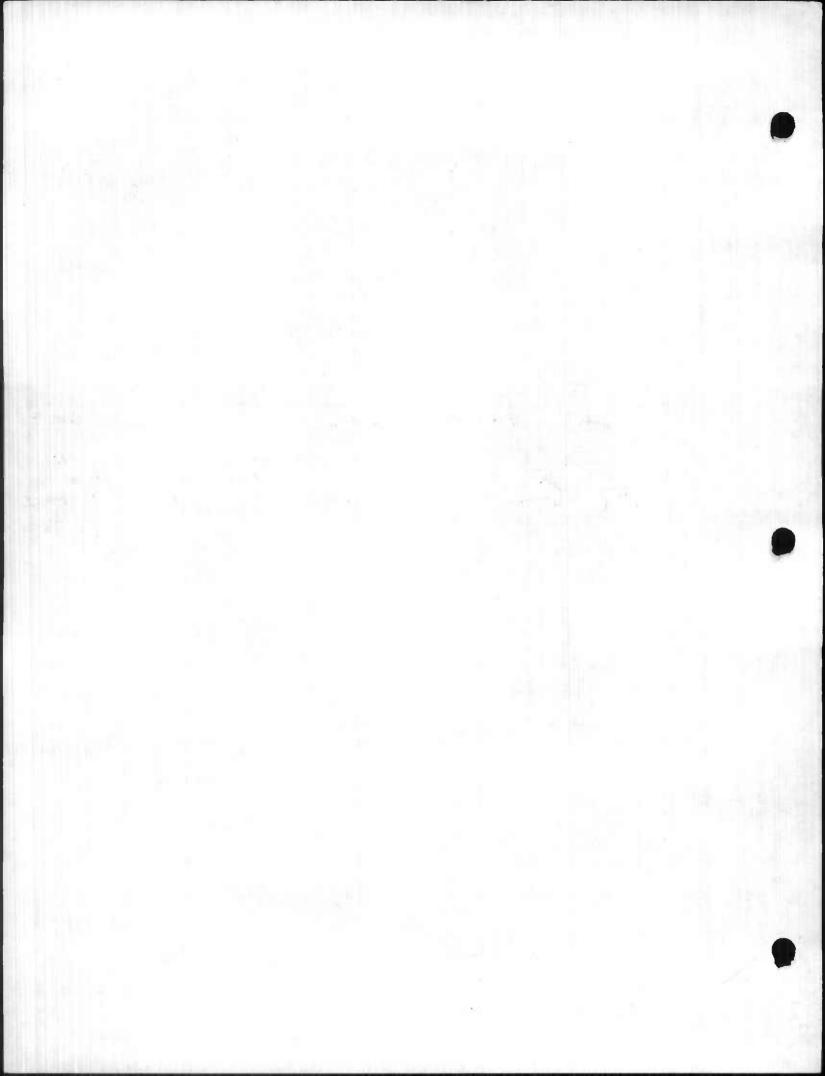
1200 E. Fayette St. Balt. MD 21202

29c. Licensa number

D0051094

29d. Date signed (Month, Dey, Year)

8 24 00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Data of Death **Physician** August 58 Am Frances M. Thomas 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number, 4c. County of Death **Examiner** Kosedale Rout C/Wave 6. Sax Hospita Center imone H Under 24 Hrs. 8. Date of Birth Hours Min. Worth Day, If Under 1 9. Birthplaca (State or Foreign Country) Mary Land Social Security Number **Funeral** Days 1□ M 2X) F 74 Yrs 212-22-9352 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Baltimore Funeral Director Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21111 16401 JM Pearce Rd United States 12. Was Decedent Evar in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indien, Black, Whita, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Frank W. Miller Marie Elizabeth Crispens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health, Simeon D. Thomas / husband 16401 JM Pearce Rd Monkton, MD 21111 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State Chesapeake Crematory, Inc. 8/24/00 4 ☐ Donetlon 5 ☐ Othar (Specify) Beltsville, MD 22. Name end Address of Facility CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286 21. Signature of Funeral Service Licansae Xaura (Yordesly 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediata Causa (Final diseasa or condition resulting in death) /Medical avaio Examiner Due to (or es a consequence of): Physician/Medical Examine Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wera autopsy findings evailable prior to completion of causa of death? Be Completed 24a. Was an autopsy performed? page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

The law requires that the death certificate be exec P.O. 1 Records. of Vital this After Division or Attending after death. within 24 hours a To the Funeral C completely filled Hospital

hom)なら re. Maryland 21215-0020

Baltimore,

Box 68760.

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Carker

29b. Signeture end title of certifier

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29c. Licensa number

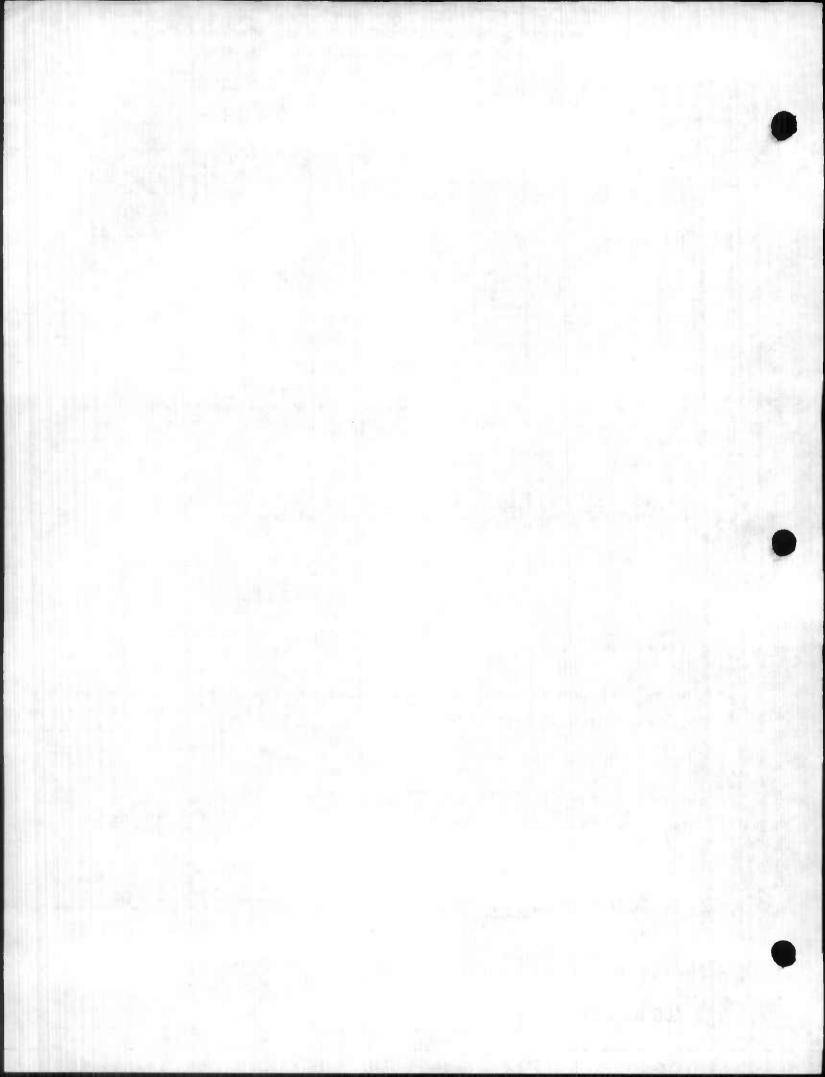
29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

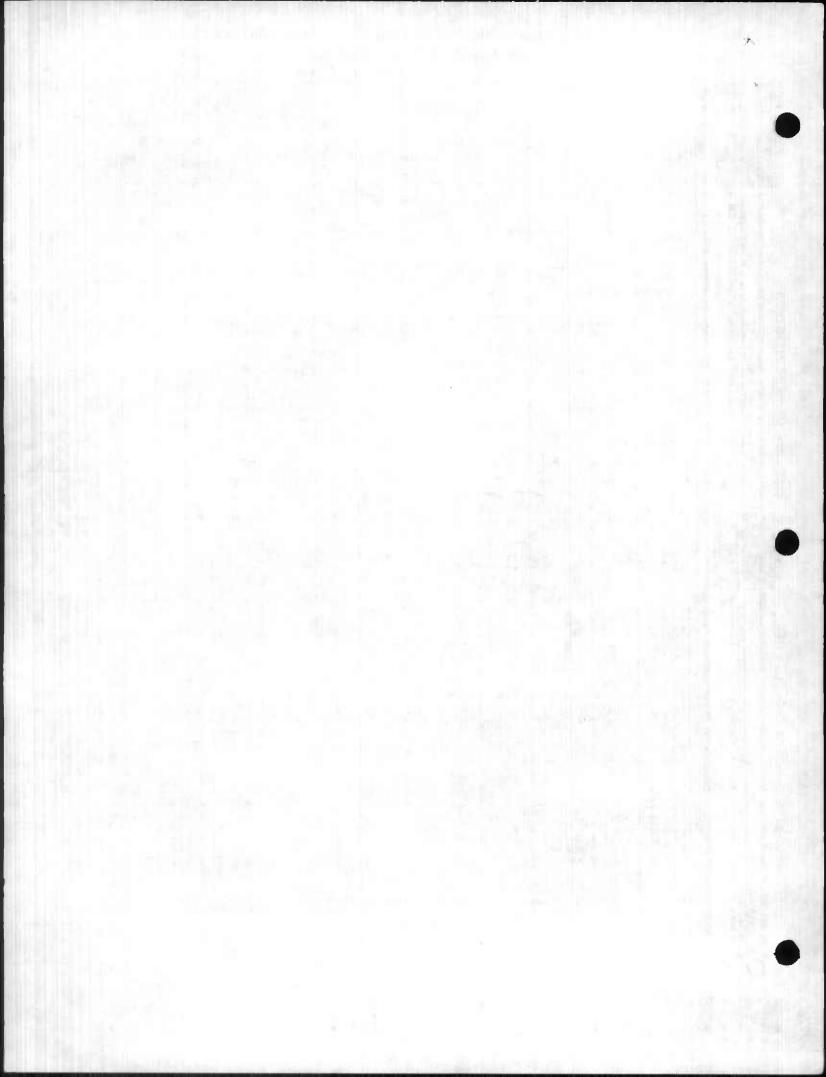
9000 Franklin Square

State



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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death AUGUST 17, 2000 4b. City, Town, or Location of Death 4c. County of Death

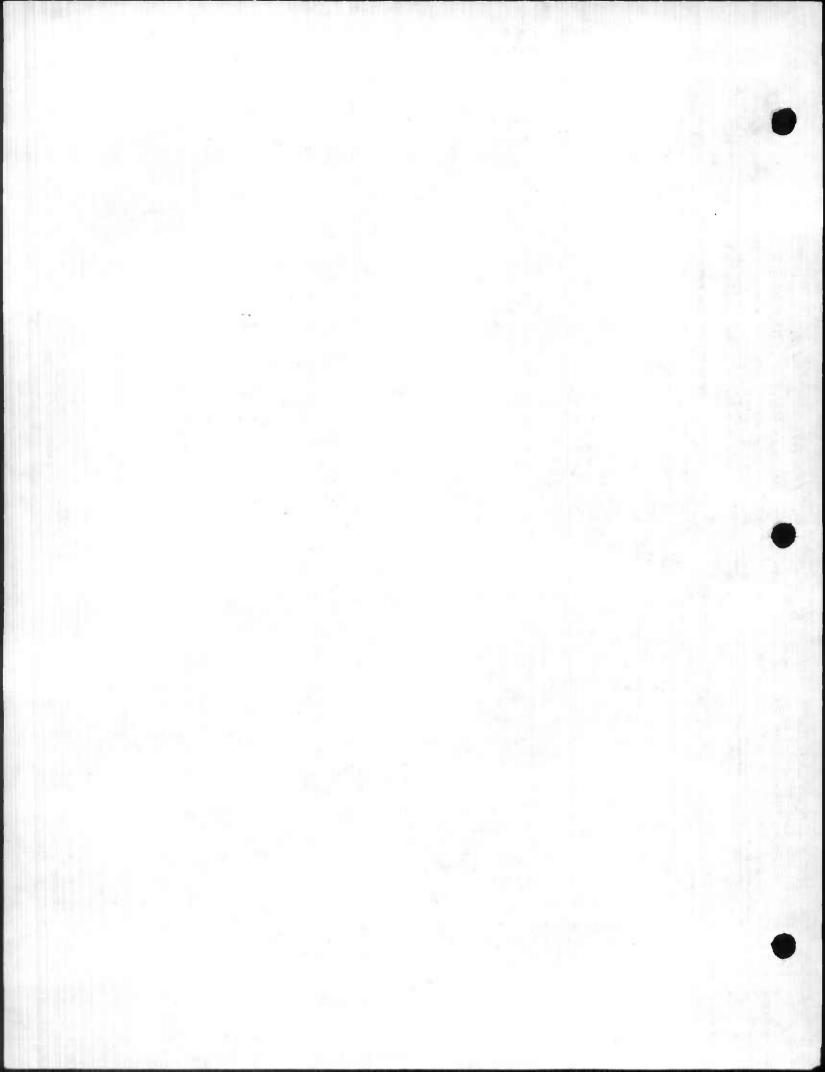
1. Decedent's Name (First, Middle, Last) **Physician** DOROTHY T. WEBER 5:15 PM /Medical 4e Facility Nama (If not Institution, giva street and number) Examiner 1111 Park Avenue #402 Baltimore N/AIf Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Days Yrs. 215-01-8186 84 Director Oct 1, 1915 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits ttem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at N/A Baltimore 1 X Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 Park Avenue #402 Funeral 21201 USA 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 2 should be filed within 72 hours after s and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Nevar Married 2 ☐ Married "natural", or 1 Yas 2 No Specify: Specify: white ð 3 Widowed 4 □ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 sales clerk retail permit. Pages 1 and 2 should be fit Department of Health and Mental Himportants if New 27 is marked other any Injury or other traument. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) 8 John C. O'Brien 2 Maude B. Ruyter 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Carol Zeltzman/daughter 208 S. Patterson Avenue Baltimore, MD 21231 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data cematary, cramatory or other place) 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata 4 Donation 5 ☐ Othar (Specify) Royald S. Wade Director 22 Nama and Addrass of Facility
State Anatomy Board 655 W. Baltimore Street medic Baltimore, MD 21201 23a. Part. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** all Carcinoma Immediete Causa (Final disaasa or condition rasulting in death) /Medical max **Examiner** Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequanca of): lan/Medical ã Dua to (or as a consequence of): 朝 Physic Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Records P by 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Tyes 2 No Vital 25. Was casa ratarred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Assidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 201No 1 Yes Certification: To to 춯 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how Injury occurred Division 1 -Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant after death Director: 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital within 24 hours a To the Funeral L edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar 29b. Signature and title of certifia, 29d. Data signed (Month, Day, Year) 29c. Licansa number wen de 208980 828 N. Eutaw St. Batto Md 21201 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

- VWIN MD 32. Registrar's Signatura

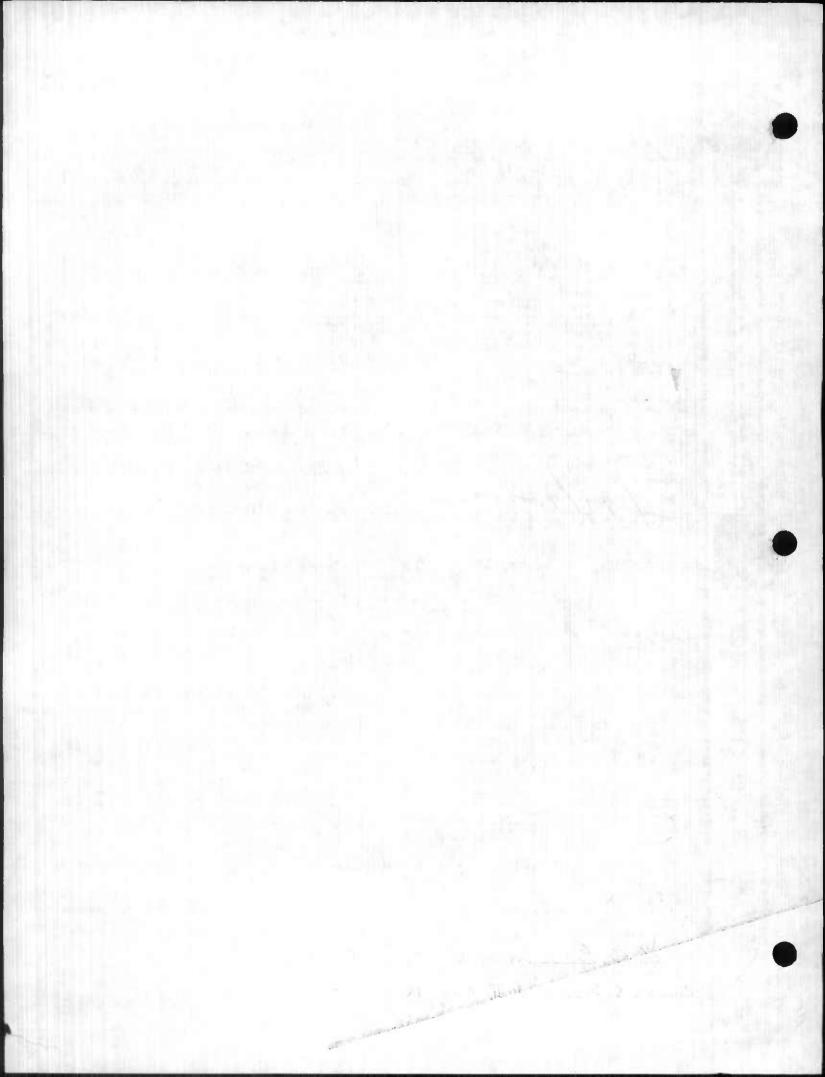
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State of Maryland / Department of Health and Mental Hygiene

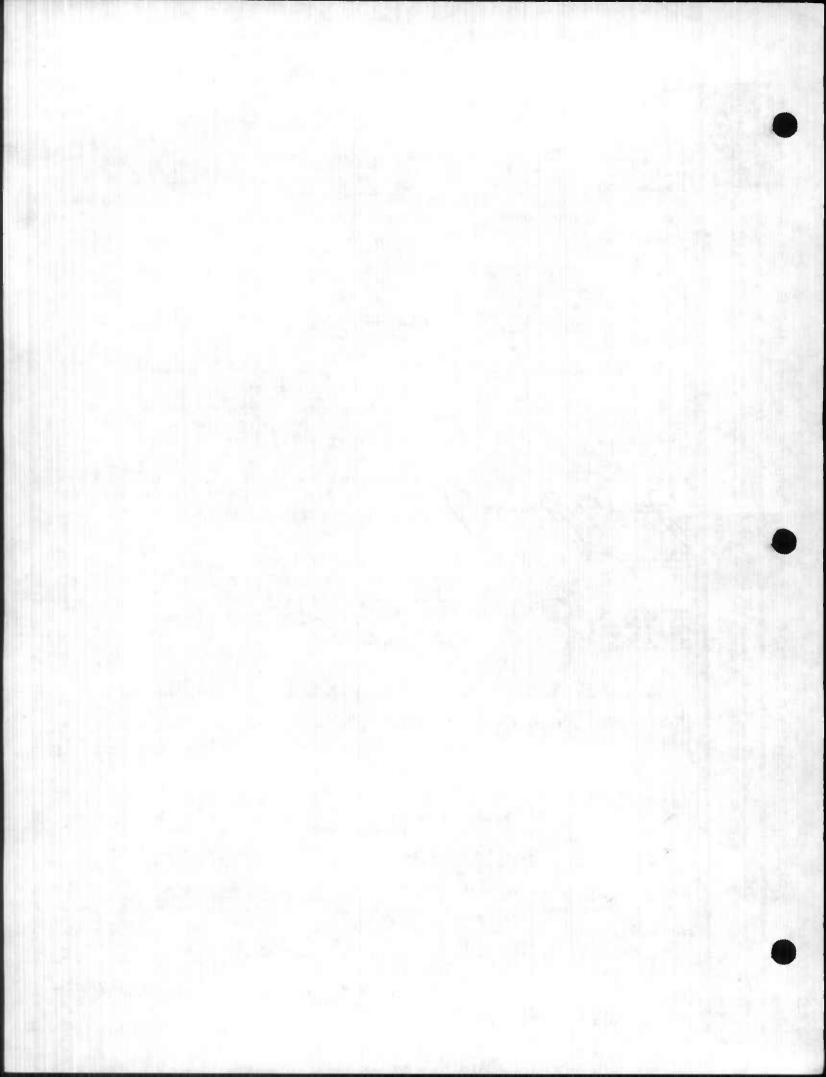
			Certificate of Death	Reg. No.	JU 26898
	1. Decedent's Nama (First, Middla, Last)			2. Date of Deeth Month Dey	3. Time of Death
Physician /Medical	Bessie M. U	Jalston		8 16	2000 10:18 Pm
Examiner	4a Facility Nama (If not institution, giva	1 11	4b. City, Town,	or Location of Death 4c. Co	unty of Death
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Funeral	5. Social Security Number 6. Sex	1.1. 200	hdey) If Under 1 Yaar If Undar 24 I Months Days Hours N	fin. 8. Data of Birth (Month, Day, Year)	9. Birthpleca (Steta or Foraign Country)
Director	Usual Rasidance of Decedent	12		6 19 28	Maryland
land land	10a. Stata 10b. County	10c. City, Town	or Location		10d. Inside City Limits
Many First	Md. NA	Halt	imore.		1) Yas 2 No
r 28s	10e. Street and Number	1	10f. Zip Code	10g. Citizar	of What Country?
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	11. Maritel Status	12. Wes Decedant Ever in U.S. Armed Forcas?	13. Was Decedant of Hispanic Original If Yas, specify Cuban, Maxican, Po	(Specify Yas or No- 14.	Race - American Indian, Black, White, atc.
or har or har		1 ☐ Yas 2 No If Yas, Give	1 Yas 2 No Specify:		ecity: D. 1
		Year or Detes:		·	Dlack
ed within 72 ho sylene. wr than "naturn rt, ma Madeal Completed	15. Decedent's Educ (Specify only highest grade	cation 16a.	Decedent's Usual Occupation (Giva kind of work dona during most of lifa. DO NOT use ratired)	working 16b. Kind	of Businass/Industry
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t and 2 Health a mar 27 is where train	Vera Internation	en. Nouchten 5.	12 Corsbu Rd. Co	storsulle, Md	. 21228
or Health	20a. Mathod of Disposition	camata	Disposition (Neme of y, cramatory or other pleca)	Data 20c. Locat	ion - City or Town, Stata
F 2 2 2 5	1 Burial 2 Cremation 3 R	emoval from State	Junea Cometera	8-25.200 Mer	malan
Baltim permit. Pa Department Important: any Injury once.	21. Signature of Fuheral Service License	10 00	22. Neme and Address of Facility	Marrel D.C	4100 4
Depart Pena	10/04/1	ster	Miller's Metropolitan	Mart 12 212	112
	Part1. Entar the disease, or compli shock, or heart failura. List only or	cations thet caused tha daeth. Do r	ot enter the mode of dying, such as car	diac or raspiratory arrast,	Approximate Interval Batween
Physician	Shock, of healt failula. List only of	ia causa on aach inie.		^	Onsat and Death
/Medical	Immediata Causa (Final diseasa or condition	Contained R	waters of Ascen	eline Harter	Caknown
Examiner	rasulting in death)	Due to (or as a c	consequance of):		
owcuted in end ial-transit		Chronic As	cerday Aostic	Dissection	19 months
end I-tran	Sequentially list conditions,	Dua to (or as a c	^		
	Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated evants	Coronary An	fery Revasculo.	rization	
6876(6876ig physicia g physicia es the bur	rasulting in death) Last	Due fo (or es e c	onsequence of):		
		<u>. — — — — — — — — — — — — — — — — — — —</u>			
Box eath cert attendin I for use	D. d. I. Ohb		Manual Company	20h Didishaan va	a constitute to the server of death 2
s, P.O. Box is that the death certified by the attending be detached for use by Physician/M	Part II. Other aignificant conditions con	itributing to death but not rasulting in	the undarilying causa given in Part I.		e contribute to the cause of death? No 3□ Probably 4□ Unknown
that if that he dette	Hypertension,	Disheles Mellitus	, Covarang Arter	7	NO SEPTODEDY VEGOTIATORI
I Records, P.O. Box The lew requires that the death cer tite has been signed by the attendin page 2 should be deteched for use completed by Physician/N	1	1 1, 1	P. /	24a. Wes an autopsy performed?	24b. Were autopsy tindings available prior to
s bee	sease, can	gestive Heart	tailure	- penomed	complation of causa of death?
Il Record The lew requir nate has been si page 2 should Completed				12 Yas 2 0 !	No 1 Yas 2 No
/ital			28. Place of	Death (Check only one)	
of Vita Physician: rhis certific ral director,	axaminar? N⊠ Yas 2 No	lospitel: Inpatiant 2 ER/Ou	patient 3 DOA Othar: 4 Nursir	ng Home 5 Residence 6	Other (Specify)
no no sg Ph			ima of 28c. fnjury at njury Work?	28d. Describe how injury of	ccurred
Division of Vital us or Attending Physician: The star death. at Director: After this certificate led in by the funeral director, ps Certification: To Be Co	2 Accident invastigation		M 1 Yas 2 No		
IVIS re-Am re-ct r	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At homa, fa building, etc. (Specify)	rm, street, fectory, office	28f. Location (Street and h City or Town, Stata)	lumber or Rural Routa Number,
O SECTION O					
he Hospit in 24 hour he Funer pletely fill edical	29e. Certifier 1 Certifying Physical Check only 2 Medical Examin	ter: On the basis of axamination and	deeth occurred et tha time, date and pi for invastigation, in my opinion, death o	ace, and dua to the cause(s) an occurred at the time, date and pl	d manner as stated. ece, and due to tha cause(s)
Division of Vital Rec To the Hospital or Attending Physician: The lew within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		end mannar stated.	29c. License number		igned (Month, Dey, Year)
5. <u>₹</u> 5.8	29b. Signatura and titla of certifier	1 1		, ,	
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1	30. Nama and addrass of person who co	mpleted causa of daath (Item 23a) (// 441 4	
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State Registrar	AUG 24 2	Dentino	p sparks		

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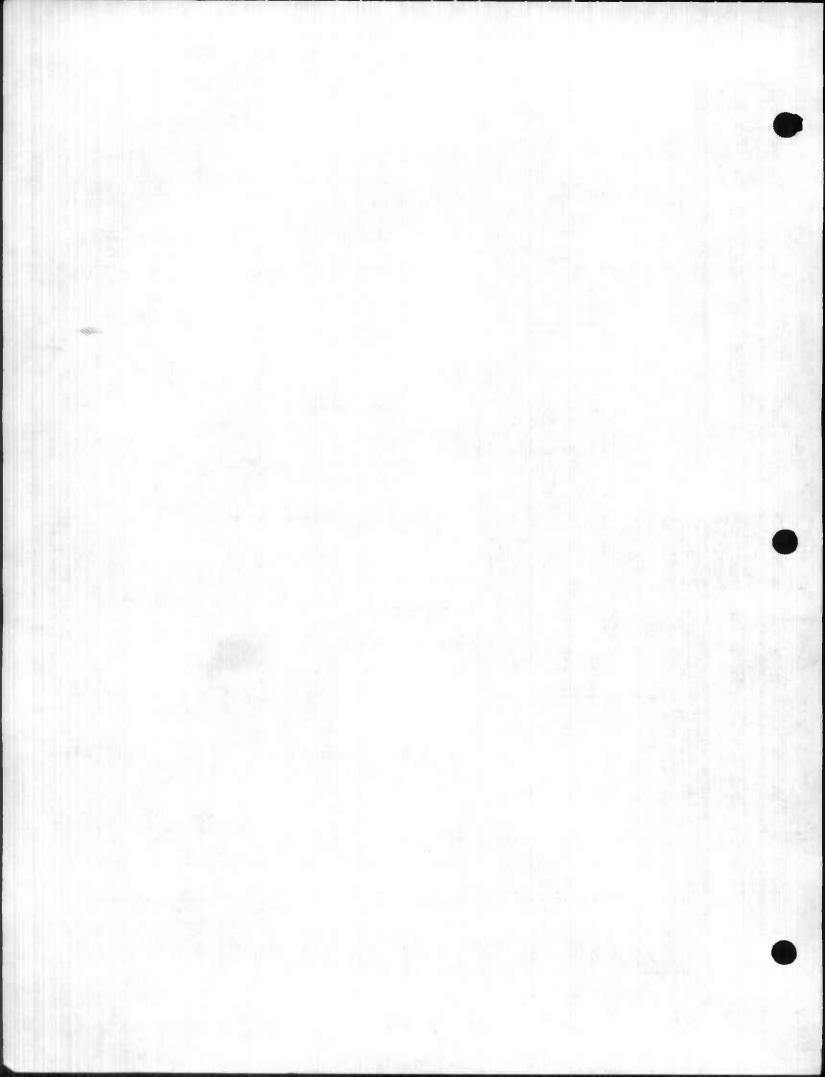
State of Maryland / Department of Health and Mental Hygiene 00 26899

					Certi	ificate	of	Death			Reg. No.		6	.0000
1 100		1. Decedent's Name (First, Middle, I								2. Date of De				3. Time of Death
	ician	JOHN FR	ANCIS V	NEBE	R					AUGUST	Day	/	900	4:25 AN
	dical niner	4a Facility Name (If not institution, g						4b. City, To	wn, or Lo	cation of Dear	7	County of I		
Exal	milei	Johns Hopkin	s Bavview					Balt	imo	re		N/A		
5				(In yrs. last bi		If Under 1	Year	If Under		9 Date of Bi	rth		Birthpla	ace (State or Foreign
Funer Direct		218-58-7550	103M 2□ F	47	Yrs.	Months	Days	Hours	Min.	11/25/	1952		ary]	
P .		Usuel Residence of Decedent 10e. State 10b. County		10c. City, Toy	wn or Loca	ation							10	d. Inside City Limits
e Menyla la-f sho	ctor	MD	n/a				tim	ore						1⊠Yes 2□No
death with the Meryland ma 23a or 28a-f show	al Director	10e. Street and Number 341 S. East Ave	nue			10f. Zip C		1224			10g. Citiz	zen of Wha	it Count	ry?
- P 2 2	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1			as Decede Yes, specif		lispanic Or an, Mexice Specify:		ecify Yes or N Rican, etc.)		14. Race - Black, \ Specify:	America White, e	etc.
72 hours	pete	15. Decedent's (Specify only highest of	Education	168	. Decede	nt's Usual	Occup	ation during mos	of work	ina	16b. Kir	nd of Busin	ess/Ind	ustry
within then.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		NOT use		during mos d)			Mar	cket o	of H	ighlantown
		17. Father's Name (First, Middle, La	st)		-			18. Moth	er's Name	e (First, Middle	, Maiden	Sumame)		
# 0 5 A #	To Be	John Weber					- 15	Mari	a De	iter				
Maryla 12 should h end Men 7 le marke treumetic	-	19a. Informant's Name/Relationship	(Type, Print) Wife	19	b. Meiling	Address (Street	and Numb	er or Run	al Route Numl	per, City or	Town, Sta	ete, Zip	Code)
C = N -		Elizabeth Weber		3	41 Sc	outh	Eas	t Ave	nue,	Balti	more,	Mary	ylan	d 21224
ges 1 and tof Health If Hem 27 or other tr		20a. Method of Disposition		20b. Place c	of Disposit	tion (Name	e of	ca)	I	Date	20c. Lo	cation - Cit	y or To	wn, State
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Baltiir pemit. P Departme Importan	6000	21. Signature of Funeral Service Lic	ensee	58						seph N. et, Balt				Funeral Home 21224
BOX 68760, eath certificate be executed Example of the control of	_	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	b	Due to (or as a	a conseque	enca of): ence of):	em	OCENTIL	MA PICATION	A MANAGER BY M	EDICAL EXI	MAINER		
P.O.	Completed by Physician/Me	Part it. Other significant conditions Peripheral	dd contributing to death but				use giv	ven in Part	1.			/		the cause of death?
DIVISION Of VITAI HECORDS, for Attanding Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be e.	pleted										s an autop lormed?	osy	ava	ore autopsy findings vilable prior to repletion of ceuse deeth?
VITAL REC	E O									10	Yes 2)	No	1	Yes 2□ No
Francisco.	Be	25. Was cese referred to medical						26. Plac	e of Deat	h (Check only	one)			
Of Vita Physician: this certific ral director,	To	examiner?	Hospital:	nt 2 ER/O	Outpatient	3 DOA	Oth	ner: 4 N	ursing Ho	me 5 Res	idence (6 MOther	(Specify	Hospital
9 Ph	ä	27. Manner of Death	28a. Date of injur (Month, Day	y 28b.	Time of Injury	28	c. inju	ry at		28d. Describe	how injur	y occurred		
OIVISION or Attending I after death. Director: After I in by the fune	atio	1 Natural 5 Pending 2 Accident investigat	ion 08-19-0		. 1 - 1	Рм		Yes 2	No	Fell in	n the	2 str.	eet	
Atte	ti ci	3 Suicide 6 Could not determine	be 28e. Place of inju- building, etc	ry - At home, f	farm, stree	et, fectory,	office				(Street an		or Rura	Route Number,
DIV al or A of in b	Certification:		5200 Blo		ern f	Aue.				5200 E		~ 1	ern	Aue.
DIVISION To the Hospital or Attanding in within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical		Physician: To the best of aminer: On the basis of end menner ste	f my knowledg examination a	e, deeth c									
To the Within To the comple	Me	29b. Signature and title of certifier	STOTION STO	1.		29c.	Licens	se number			29d. Dat	te signed (Month, I	Day, Year)
F 3 F 8		16.1.	11.11.	1					-00	7				
		UM L	1 11/1	4.40		/	1		00		.//	90)	1	22,2000
2		30. Name and address of person wh	o completed cause of de	eath (Item 23a)	(Type, Pr	rint)	-	Augus	110	Rulli	MAGO	m) =	21224
	State	31. Date filed (Month, Day, Year)	an Bestell	r's Signature	1	a sel	00	uls	iuc,	Dalta	MORE	-)-11) 0	Tout
Regi		31. Date filed (Month, Day, Year) AUG 2 4	2000 32. Hegista	Lyw.	1	17		1						



State of Maryland / Department of Health and Mental Hygiene 00 26900

			Certific	ate of	Death		Reg. No.		
	1. Decedent's Name (First, Middle, La	st)				2. Date of D		Voor	Time of Death
Physician /Medical	Kim T. War	ren				August	20°, 20	00 1:	1:20 AM
Examiner	4a Facility Name (If not Institution, giv				_	or Location of Dea		y of Death	
	Gilchrist Hospice				Towson			imore	
Funeral Director	5. Social Security Number 6. S 560-15-7043	ex	Yrs. If Ur Mont	hs Days		8. Dete of B (Month, D Feb.14	orth Year) 1958	9. Birthplece Country) Marylai	(Stete or Foreign
2 .	Usuel Residence of Decedent 10a. Stete 10b. County	100 0	ty, Town or Location					10d l	nside City Limits
athor all at at at at at at at at at at at at at	M1 N/A		Baltimore						Yes 2□No
or 28a-f a notifie Directo	10e. Street and Number			Zip Code			10c Citizen of	What Country?	
) ther death with the Ma rivers 23e or 28e-ts siner must be notified Funeral Directo	6717 Park Heights	Avenue		1215			United	States	
r day	11. Merital Stetus	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Wes De If Yes,	ecedent of H specify Cube	tispanic Origin? en, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	lo- 14. Re Bis	ca - American Ir ick, White, etc.	ndien,
by Est.	3 ☐ Widowed 4 ☒ Divorced	1 Yes 2 No If Yes, Give Yeer or Dates:	1□ Ye	s 210 No	Specify:		Speci	» Black	
72 72 72 72 72 74 72 74 72 74 74 74 74 74 74 74 74 74 74 74 74 74	15. Decedent's Ed (Specify only highest gra	fucation (de completed)	16a. Decedent's U	Jsuel Occup	ation during most of	workina	16b. Kind of E	Business/Industr	у
I Z1Z15-0 ad within 72 ho ygiene. Are than "natum At the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired	d)		1000		
Cor the Cor		2	Bus Dri	ver			Greyh		
Be C						Name (First, Middl	1-1-2	me)	
thould be ad Mental marked of marked				10:		hy Harri		0 7. 0	
Mari 12 sh 7 is m	19a. Informent's Name/Relationship (Spence Aaron Warre	Type, Print) en/Son	9427 S.			Rural Route Num			(e)
s 1 and 7 Health hem 27 other to	20a. Method of Disposition		Place of Disposition (art Ave	Data	cago, II	60619 · City or Town,	State
5 5 5 5	1 Burial 2 X Cremetion 3	Removal from Stete	cemetery, cremetory	or other plea					
Adams .	4 □ Donation 5 □ Other (Specification 21. Signeture of Funeral Service Licer		esapeake C					lle, MD	
Depart Depart Import any inj	21. Signature of Furieral Service Licer	/ / / -	CÁFĂ"	Steph	en D. L	ohrmann	P.A.		
NO PERSONAL PROPERTY.	Xaura Ct	Vandes/4)	8717	Green	Pastur	es Drive	Baltimo		21286
	23a. Part1. Enter tha disaesa, or com shock, or heart failure. List only	one cause on each line.	in. Do not enter the t	node of dyli	ng, such es can	olac or respiratory	arrest,	Inte	rvai Between set and Death
Physician /Medical	Immediate Cause (Fine)	11 (Kins	0	5000			15	
Examiner	disease or condition resulting in death)	· Hodg	Kens	1	36 415	. e		10	mont
The same of		Due to/	or as a consequenca	of):					
n and in-transit		b		-6					
n and laster laster Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequance	01):					
ficate be physicia a the bur edical	thet initiated events	C. Due to (or as a consequence	of):					
	resulting in death) Last	200101	5. 45 a 55/150q 55/150	0.,.					
3 2 5 6	May all and a second	d							
at the death cert dby the attendin- etached for use Physician/M	Pert II. Other algnificant conditions of	ontributing to death but not re-	sulting in the underlyi	ng cause giv	ven in Pert I.	23b. DI	d tobacco use c	ontribute to the	cause of death?
time of tythe stached						10	Yea 20 No	3 Probabl	y 4 Unknow
1 68 A									
per per	and the second second second					24a. Wa	s an eutopsy formed?	availab	utopsy findings le prior to
defant. The law requesting page 2 should						nen.		of daet	ntion of cause h?
att Has A						1 🗆	Yes 2 No	1 ☐ Ye	s 2 No
dan: ector, Be C	25. Wes case referred to medical				26. Placa of	Death (Check only	v one)		1
	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Oth	her: 4 Nursin	ng Home 5 ☐ Re	sidence 6	ther (Specify)	tospia
	27. Mannar of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo	ry at	28d. Describe	e how injury occi	rred	
at or Attending P in after death. at Director: After a of in by the funeri Certification;	2 ☐ Accident investigation	1	М		Yes 2 No				
Title of	3 Suicide 6 Could not b datarmined	28e. Place of Injury - At t building, atc. (Speci	nome, ferm, street, fer	ctory, office		28f. Location City or T	(Street end Nun own, Stata)	ber or Rurel Ro	ute Number,
that or Attending Phyras are after Goath. The Committee of the Committee				100					
To the Hospital within 24 hours To the Funeral completely filter Medical C	(Check only 2 Medical Exam	ysicien: To the best of my kniner: On the basis of examine							
the He thin 24 mplets Medik	one)	and manner steted.							
0000 2	29b. Signature and titlerof certifier	10	11.1	29c. Licens	se number		A Dete sign	ed (Month, Day,	7 4 2 3
P F F G		MM ICU	, uul	11.10	CANS		429US	1001	~ 000
F#F5	All Whom	7	, ,	100	3 0 00		1		
m	30. Name and addrass of person who	completed cause of death (Ite	2	1/0	1	6 Sd	· D	Ob 100	۵ > -
B	30. Name and address of person who	completed cause of death (Ite	6701	N.	Chr	- rles 57	, Bc	lfs, in	2 212



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 2000 12:15 AM Margaret Marie Adams /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health - BelAir BelAir Harford If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 11/14/1907 5. Social Security Number 9. Birthplaca (State or Foreign 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Maryland 212-34-9848 92 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hame 23s or 28s-f ahow the Medical Examiner must be notified at 1X Yes 2 No Director Penn. York York 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 182 Crown Pointe Drive 17402 United States Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3 M Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "na any injury or other treumatic event, my Meda. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be August Vincent Seitl Barbara Bartholomey 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Susie / Daughter 182 Crown Pointe Drive York, Pennsylvania 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 8/4/2000 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21 Signature of Funeral Service Licenses Medalor 23a. Part1. Enter the disease, a complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceusa on each line. Maryland 21213 Approximete Interval Between Onset and Death **Physician** Obstructive Palmonary Disease /Medical Immediate Cause (Finel diseasa or condition rasulting in death) **Examiner** Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician the burial Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached 1 Yes 2 No 3 Probably 4 Unknown Completed by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, streel, factory, office building, etc. (Specify) filled in by 4 Homlcide the Hospital 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29b. Signature and tille of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 North South Arenul

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

AUG 8

Registrar's Signature

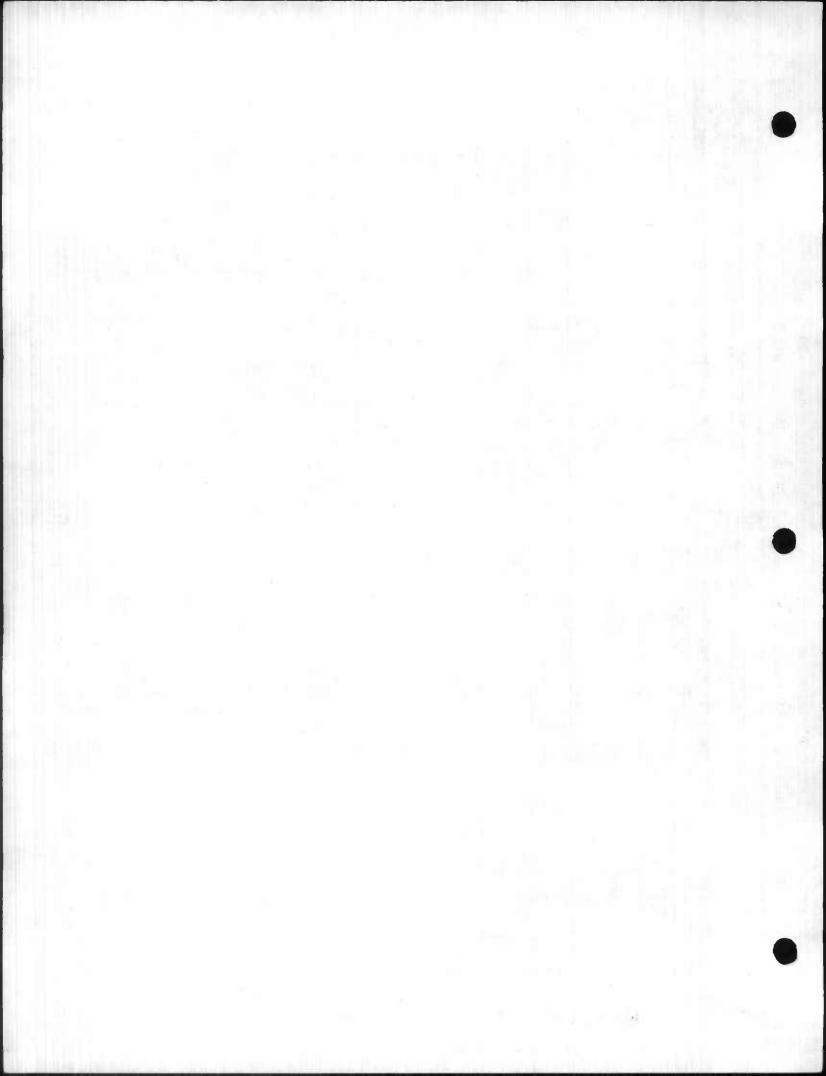
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State of Maryland / Department of Health and Mental Hygiene

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						Cei	rtificat	te of	Death			Reg. No.	00	409	06
	Db		1. Decedent's Name (First, Middle, L	ast)			-12				2. Date of De Month	ath Day	Year	3. Time o	f Deeth
114	Physici Medie/		Carl John Bec	k							August	6,	2000	10:33	AM
	Examir		4a Facility Name (If not institution, g	ive street and num	nber)				4b. City, To	wn, or Lo	ocation of Death	4c. Cou	nty of Death		
	1		Stella Maris Ho						Tow				ltimo		
	Funeral Director		219-58-1788	Sex 100 M 2□ F	7. Age (In yrs. 49	last birthday) Yrs.	If Under Months			24 Hrs. Min.	8. Dete of Bir (Month, Da Nov. 7	th y, Year) , 1950		olace (State otry) arylar	
	pue *		Usuet Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	Lity 1 imits
	se-f sho	Director	Maryland Ha	arford			Joppa							1 🗆 Yes	20 No
	burs effer death with the Maryland rail, or ferms 28a or 28a-f show Examinar mount be notified as		10e. Street and Number 1619 Reid Drive				10f. Zip	Code	21085			U.	of What Cou	ntry?	
	9 6	Funeral	11. Merital Status	12. Was Deced	dent Ever in U ces?	,S. 13.	Wes Dece	dent of	Hispanic Original	gin? (Spo	ecify Yes or No Rican, etc.)	- 14.	Rece - Ameri Black, White		
ш.	ours effer ral', or he	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes : If Yes, Give Year or Da	2 ∏ No e tes:				Specify:				cify:	White	
a.m.	72 hc	9	15. Decedent's I			16a. Dece	dent's Usu	al Occu	pation during most	of work	ina	16b. Kind o	Business/In	dustry	
2000 IO:33 a.m. Maryland 21215-0020	permit. Peges 1 and 2 should be filled within 72 hours eft Department of Heelih and Mentel Hyglene. Important: if flem 27 is marked other than "natural", or any injury or other treumatic event, the Medical Event and	Completed	Elementary/Secondary (0-12) 11th Grade	College (1-	4or 5+)	life.	DO NOT u	se retire	stalle			F	Loorin	g	
g g	事	Be C	17. Father's Name (First, Middle, Las	4)					18. Mothe	r's Name	e (First, Middle,	Maiden Sun	ame)		
<u>8</u>	Ment by Ment b	To	Clyde Beck						Ka	ther	ine l	Inknow	1		
Mary	and and		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Stree	t and Numbe	or Aun	al Route Numbe	er, City or To	wn, State, Zij	Code)	
	end m 27		Rose Kozlowski (Friend)	I				ive, J	oppa	, Maryl				
Baitimore,	Peges 1 ent of H mt: 14 fte ry or off		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Special Control of the Control		gate	Place of Disponentery, cremetery, cremetery, cremetery	natory or d	other pla		la la	Date /9/00		more	own, Stete Maryl	and
AUGUST Baitim	Departm Mportal any Inju		21. Signature of Faheral Service Lice		GIG	22	. Name er	nd Addr	ess of Fecilit	у	Home of				and
4			23 Part Enter the disease, of conshock, or heart failure. List only	10-1							ad, Bel		Maryl	and 21 Approxime Interval Be	
	Physician /Medical Examiner	96	Immediate Cause (Final disease or condition resulting in death)		INOID ?								1 4 1 1	Onset and	Deeth
B	and el-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (d	or as a consec	uence of):	:							
68760	certificate be executed rightly physician and see as the buriel-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (c	or as a conseq	uence of):								
ŏ	9 H 8	2		l d											
a a	deeth ed for u	등	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying o	ceuse gi	iven in Pert I.		23b. Dld	lobacco une	contribute 1	o the cause	of death?
P.O.	equires thet the en signed by th ould be detech	by Physician/									10	Yes 2 N	o 3 Pro	bably 4X) Unknowi
CARL	2 2 2	Completed b										an autopsy rmed?	a	fere autopsy vailable prior empletion of death?	10
Œ	The low ate hes b pege 2 s	Somp									10	Yes 2 N		Yes 2] No
Ta Ta	yalclen: The s certificate director, per	Be (25. Was case referred to medical examiner?						26. Place	of Deet	h (Check only o	ne)			
of Vital	Physicien: this certification	0	1 ☐ Yes 2 No			ER/Outpatier		UA			me 5 Resi			MOSI	PICE
ion	Attending Pire death.	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		I Injury , Day Year)	28b. Time of tnjury	M	28c. Inju Wo 1 [nyat ork?]Yes 2 □ l		28d. Describe	how injury oc	curred		
Division	s effer de if Directo ed in by t	Certification:	3 Suicide 6 Could not determined	4 288. Place (of Injury - At h g, etc. (Specif	ome, ferm, str	eet, fector	y, office			28f. Location (: City or To		im <i>ber</i> or Rur	al Route Nur	n <i>ber</i> ,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely illed in by the funeral di	edical	29a. Certifier (Check only one)	hysician: To the base miner: On the base and manne	sis of examina	wledge, death tion and/or in	occurred vestigation	et the t	ime, date and opinion, deal	d place, th occurr	and due to the red at the time,	cause(s) end date and pla	menner es : ce, and due !	stated. o the cause((s)
	within To th	Me	29b. Signature and title of certifier	. 4 -			29	c. Licen	se number			29d. Date si			A ET
			16	75			1)43	3725			21	8/0	O	
	10		30. Name and address of person who DR. TARIO MAHMOO			n 23a) (Type, Y VALL		0	TTMANT	MII	MD 210	0.2			
	Sta	te	31. Date filed (Month, Day, Year) ALIG 1 0 200	₩ Re	gistrar's Signa		Ana	20 11		LUIT	MD 210	7.			

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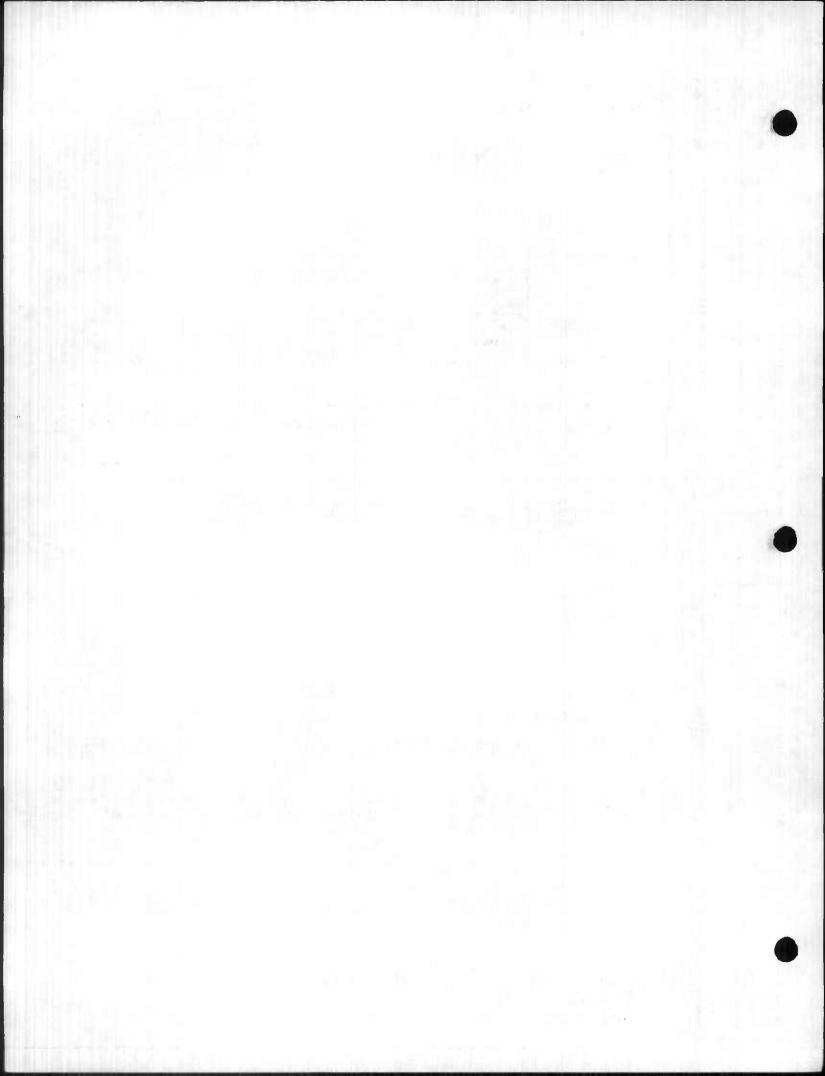


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) Day 7, 2. Data of Death 3. Tima of Death Month **Physician** Carolyn 2000 2:20 A.M. B. Bunce August /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Middle River Baltimore Ivy Hall Nursing Home Months Days Hours Min. 8. Data of Birth (Month, Day, Year) March 2, 1932 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 F Yrs. Director 215-28-3539 68 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location Show t0d. fnside City Limits r than "natural", or items 23s or 28s-f show The Medical Examiner must be notified at 1 ¥ Yas 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 4122 Townsend Avenue U. S. A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, etc. filed within 72 hours aftar 1 Nevar Marriad 2 Married 1 ☐ Yas 2 🕱 No If Yas, Giva 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Year or Datas: white Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12th Grade Homemaker Own Home i. Pages 1 and 2 should be filed vitinent of Health and Mental Hygie tant: if item 27 is marked other tigury or other traumatic avant, in Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Sumama) Be William Snyder Vera Holston 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 4122 Townsend Avenue, Baltimore, Maryland 21225 Leonard V. Bunce (Husband) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or page. 4 Donation 5 Other (Specify) Bel Air Memorial Gardens 8/9/2000 Bel Air, Maryland 21. Signatura of Funaral Service Licensee 22. Nama and Address of Facility Schimunek Funeral Home of Bel Air, Inc. mark 610 W. MacPhail Road, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** 6 coko Immediate Cause (Final disease or condition rasulting in death) Oumania, /Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, physician s the buria Physician/Medical Dua to (or as a consequence of): 88 been signed by the attendin should be detached for use Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Was casa rafarred to medical 26. Placa of Death (Check only one) axaminar? Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Panding invastigation 1 Naturat 24 hours efter death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Cartifier completely (Check only one) within 2 2 29c. License number D - 38 7-54 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 08-08-2000 MD 30. Nama and addrass of perspn who completed causa of death (Item 23a) (Type, Print) EASTERN BLVD, MD-21221.

State Registrar 31. Data filed (Month, Day, Year)

AUG 1 0 2000

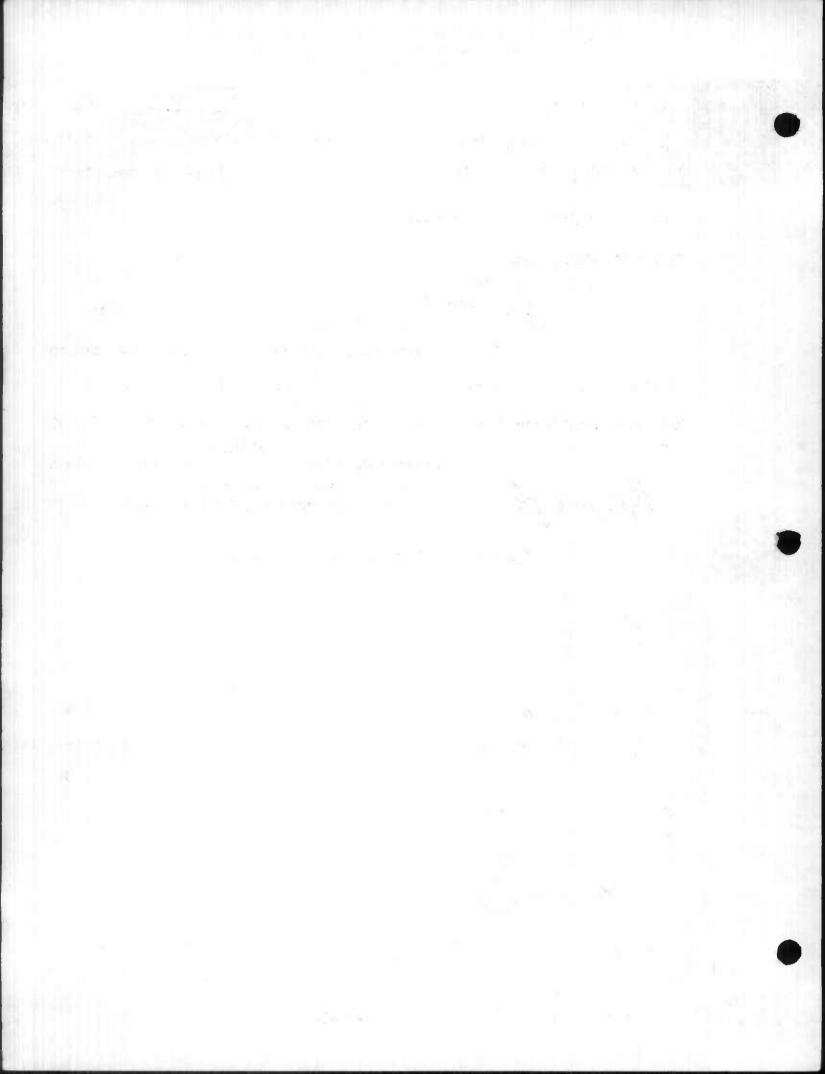
MALIKA WASCEM. 709. 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate	of Death		Reg. No.	0 4	0904
Physic		1. Decedant's Nama (First, Middla, Las Charles (AM	100				2. Data of De Month	Day	Yaar	3. Tima of Death
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or the	by Funeral Director	11. Meritel Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☼ Yas 2 ☐ No if Yas, Giva Yaar or Dates: 195		if Yas, specify	t of Hispanic Origin? (Sp Cuben, Mexican, Puarto No <i>Specify:</i>	Rican, etc.)	Specify		tc.
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Mentel Merked of	To Be	Charles F.	Bara			Jirina	(nm		artono	wa
2 should be end Mente is marked aumatic st	-	19a. informant's Name/Reletionship (7		19b. Mail	ing Address (S	Straat end Number or Rui				
		Mildred Frances B	ara- Wife	3917	East I	Baker Avenue	e, Abin	gdon, Ma	arylan	d 21009
permit. Pages 1 end Depertment of Health Important: If Item 27 any Injury or other to anges.		20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐		o. Pleca of Disponentary, cra	ositlon (Nama matory or othe	of prece)	B/09/00	20c. Location	City or Tow	m, Stata
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	BeC	25. Was case referred to medical				26. Placa of Deal			10	100 200110
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or Attending effer death. Director: Affer i in by the fune	Certification:	2 Accidant Investigation 3 Suicide 6 Could not be	00- 51		М	1 Yas 2 No	and I	(0)		D
or At efter Direc	ertif	4 ☐ Homicide datarminad	28a. Place of Injury - A building, atc. (Spe	t home, farm, st ecify)	raat, factory, o	ffice	City or To	(Street and Numb wn, Stata)	per or Hural	Houta Number,
To the Hospital or Attand within 24 hours effer death To the Funeral Director: completely filled in by the	Medical C	29a. Cartifiar (Check only one)	sician: To the bast of my k ner: On the basis of exam and mannar stated.	nowladga, daat Ination end/or in	h occurred at to vastigation, in	he time, data and place, my opinion, daath occur	and dua to the red at the tima,	ceusa(s) end madeta and place,	annar as sta and dua to t	ted. tha causa(s)
Within To the	Me	29b. Signatura and titia of cartifier				icansa number		29d. Date signe	d (Month, D	ley, Year)
		Alyanne	J- methou	o min	D	27716		9-30	- 20	101.
154		30. Name and eddress of person who co Reyamma J. M.								
			- T		nanc	mue. 15	auth	NOK.	10	-120/
Sta Registr	-	31. Dete filed (Month, Day, Yaar)	32 Registrar's Sig	natura	1					

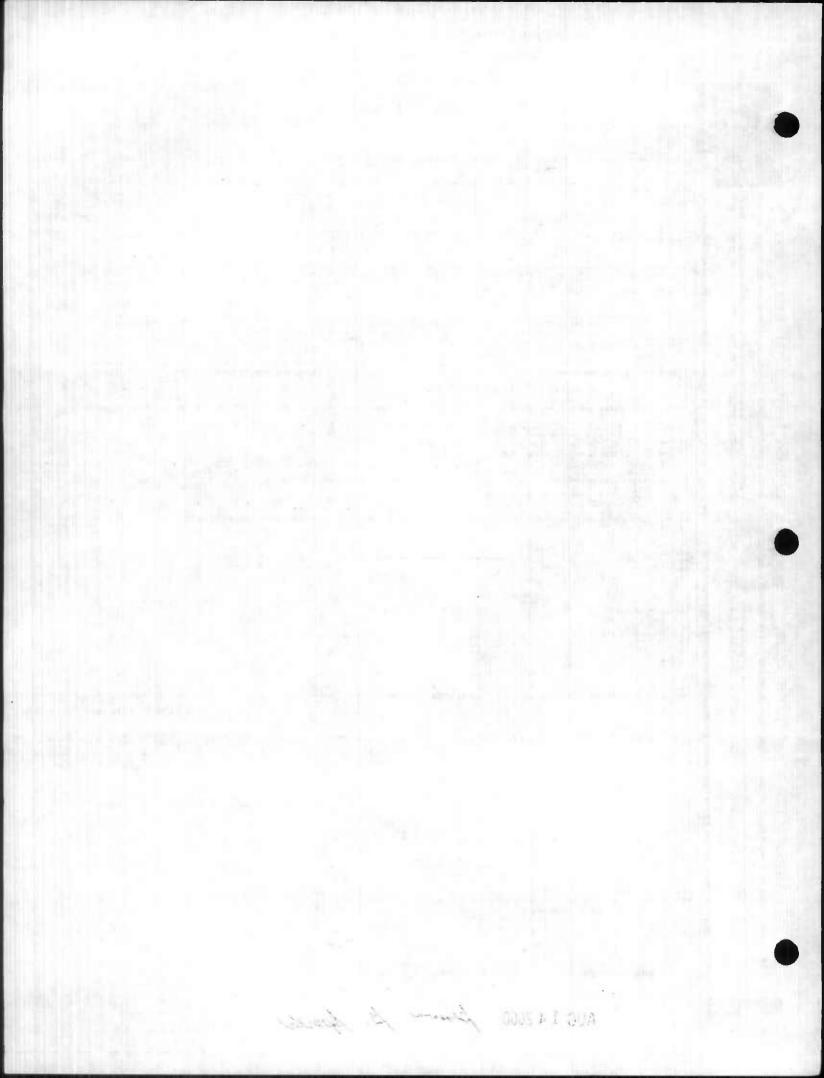
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State of Maryland / Department of Health and Mental Hygiene
2/2001 FM Certificate of Death

Allended	Item#23a pe	erraig/91 1	/ ZZ/ ZUU1 EW		001	imcale	011	Doutin			Reg. No.			
Physician /Medical	Decedent's Nam		asi) ISTOPHER	ANDRI	EW B	LOODSW	IOR]	ГН		2. Date of D Month Augus	Day	2000	ar	ima of Death
Examiner			ive street and numb				4	lb. City, To	wn, or Lo	cation of Dea	th 4c. C	ounty of I	Death	
			1 Hospi			2711		East				lbot		
Funeral	5. Social Security N	Number 6.	Sex 7.	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of B (Month, D	irth ley, Year)	9.	Country)	State or Foreign
Director	Usual Residence of	of Decedent			115.		-	1	47	Aug. (9 200	O Ma	arylan	d
0 1 1-	10a. State	10b. County		10c. City	, Town or Lo	cation						-	10d. Ins	ilde City Limits
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or 185-4 s or 185-4 s be notified	10e. Street and Nu					10f. Zip C	ode				10g. Citize	n of Wha	t Country?	
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ther death in the same same same same same same same sam	11. Marital Status		12. Was Decede		S. 13. \	Vas Deceder	nt of H	ispanic Or	igin? (Spe	ecify Yes or N Rican, etc.)	lo- 14		American Ind	ian,
F. F. B.	1€ Never Man	ried 2 Married	Armed Force							Hican, etc.)			White, etc.	
by by	3 Widowed	4 Divorced	If Yes, Give Year or Date	es:		☐ Yes 21	No.	Specify:			S	pecify:	white	
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TO THE POST	1 Burial 2	☐Cremation 3 [Removal from Sta	CE	emetery, cren	netory or oth	er pled	(e)	ν., Q.	-11-200				
orden and and and and and and and and and an		5 ☐ Other (Specuneral Service Lice		Lasi		Name and								, 114.
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Physician /Medical	Immediate Cause	(Final	PREM	ATURE I	UNGS									
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physician and s the burial-transit	Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease of that initialed eventions in death)	r Injury	c	Due to (or	as a conseq	uence of):								
0.4	resulting in death)	Last												
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0 0 0	27. Manner of Dea	5 Pending		Day Year)	28b. Time of Injury		Wor			28d. Describe	e how injury	occurred		
octor: After by the fune iffication	2 Accident	Investigation	be on Diagon	Hairar Atha	ma farm str	M		Yes 2	INO	28f. Location	(Street and	Number	or Pural Pout	a Number
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De la la la la la la la la la la la la la	29e. Certifiar	1⊠ Certifying P	hysician: To the be	est of my know	vledne deeth	occurred et	the tir	ne date ar	nd place	end due to th	e cause(s) a	nd mann	er as stated	
n 24 hou Ne Funer pletely fill edical	(Check only one)	2 Madical Exa	miner: On the besi	s of examinat	ion and/or in	estigation, in	n my o	pinion, de	ath occurr	ed at the time	e, date and p	olace, and	due to the c	ause(s)
within 24 hours after death. To the Funeral Director: At completely filled in by the fur completely filled Certification.	29b. Signature and	d title of certifier				29c.	Licens	e number			29d. Date	signed (I	Month, Day, Y	'ear)
> - 0		Mali	MZ			I)5	100	941		9	191	200	0
	30. Nama and add	ress of person who	completed cause	of death (Item	23a) (Type									
		Langfitt		9 Comm			Eas	ston	MD 21	1601				
										-001				
State	31. Date filed (Mor		1 4 2000	Istrar's Rignal	ara a	1.	-	rocks						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Preston William Blair AM August 0807 2000 10 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Washington County Hospital Hagerstown, Washington If Under 1 Yeer | If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 7. Age (fn yrs. last birthdey) Birthplace (State or Foreign Country) M 20 F Deys Hours 218-38-1475 59 Yrs July 16,1941 MD Usual Residence of Decedent 10e Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits Washington Hagerstown, 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16138 Spade Road 21740 U.S.A. 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify: White 1 ☐ Yes 2K No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Farm Elementery/Secondary (0-12) College (1-4or 5+) Farming 10th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Raymond T. Blair Elizabeth Carpenter 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) wife Jacqueline D. Blair 16138 Spade Rd. Hagerstown, MD 21740 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 Removal from Stete 4 Departure 15 Other (Specify Aug. Broadfording Memorial Hagerstown, MD Gardens 22. Name and Address of Facility 14,2000 Signature of Funeral Service 17 Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Approx shock, or hearr failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Fine) diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initialed events) Antonia Due to (or es a consequence of resulting in deeth) Last Part II Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? UBES 1 TY 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpalient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Neturel 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 s Department of Health an Important: If them 27 ie. eny injury or other treu

should be

Pages 1

72 hours after

Saltimore, Maryland 21215-0020

MD

the Medical Examiner must be notified at

Director

Funeral

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Examiner and attending physician Certification: To or Attending death within 24 hours

Physician/Medical Box Records, by Completed Be

Preston

State Registrar

DHMH 16 Rev 6/95

5 Pending investigation

6 ☐ Could not be

2 Accident

3 Suicide

29e. Certifier (Check only one) 29b. Signatu

4 Homicide

32. Registrer's Signeture

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

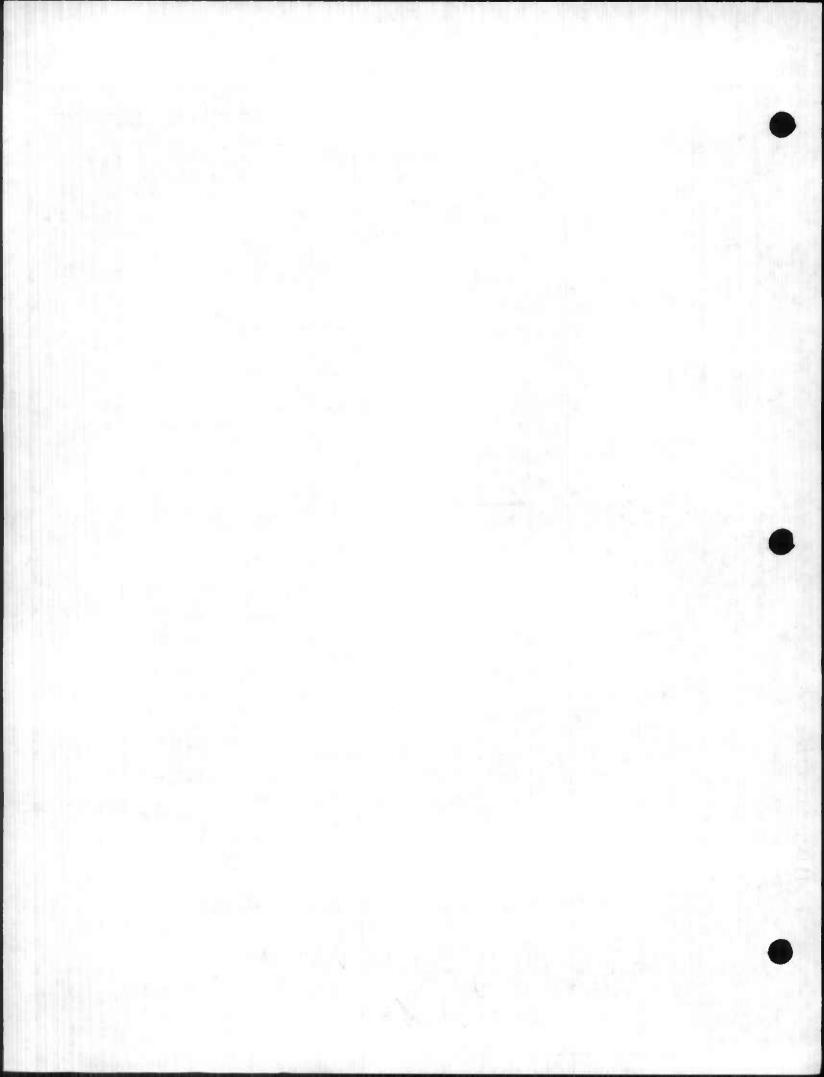
29c. License number

1 Yes 2 No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Regina M. Bonner August 0700 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hagerstown Wash

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d other than " Elementary/Secondary (0-12) College (1-4or 5+) Statton Furniture Co. 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be and Mental marked William Joseph Duffey Louise Kathleen Mullenix 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is in any Injury or other traus Christine A. Funk Daughter 1056 Bear Valley Road Ft. Loudon, Pennsylvania 17224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 8/16/00 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical (dus Sapris Examiner Due to (or as a consequence of) Physician/Medical Examine 2-3-400 Phenomia physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or as a consequence of) Due to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyse 2 No 3 Probably 4 ZUnknown uniners Treet injection, Dysphysia Records, þ Alghima Dinan 24b. Were autopsy findings available prior to completion of cause of death? respendence Certification: To Be Completed 24a. Was an autopsy parformed'i 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 40 1 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Ther Division or Attending 1 [QNatural 5 Pending investigation 4 hours after deam 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, streef, factory, offica building, etc. (Specify) 4 ☐ Homicide within 24 hours af To the Funeral DI completely filled in Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Dafe signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number A18019 AUG 14, 2000 -contino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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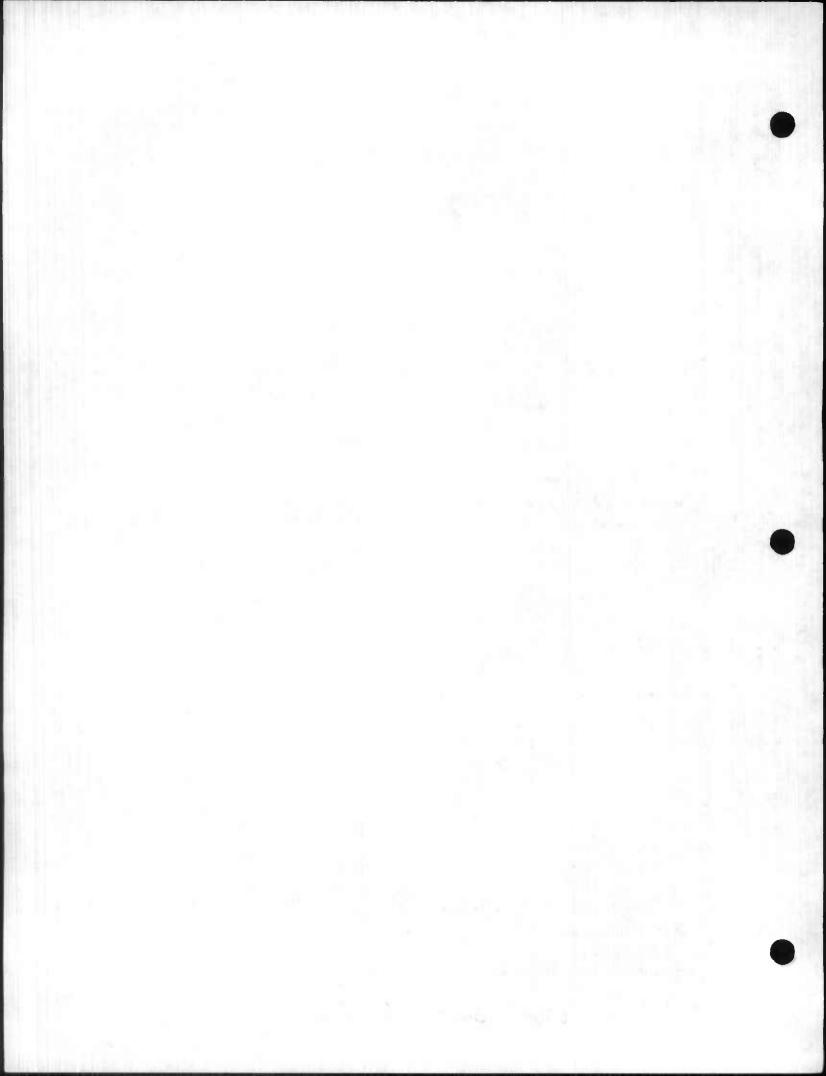
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32. Registrar's Signature

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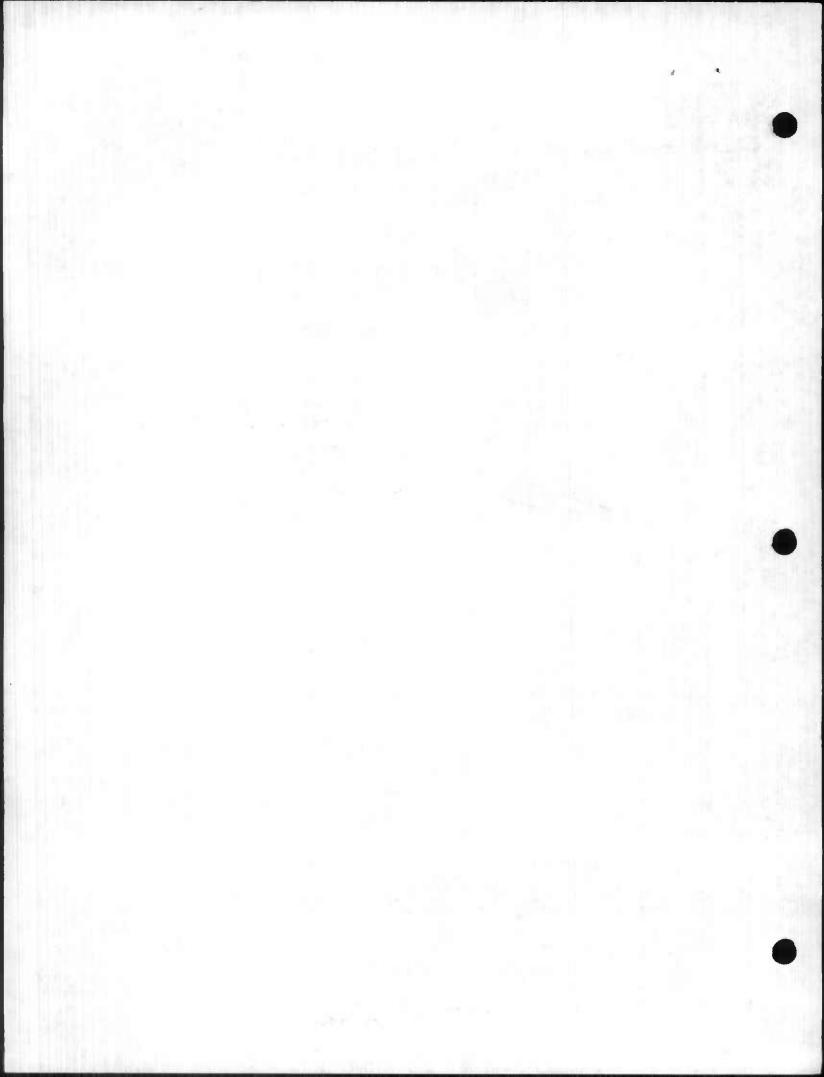
31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

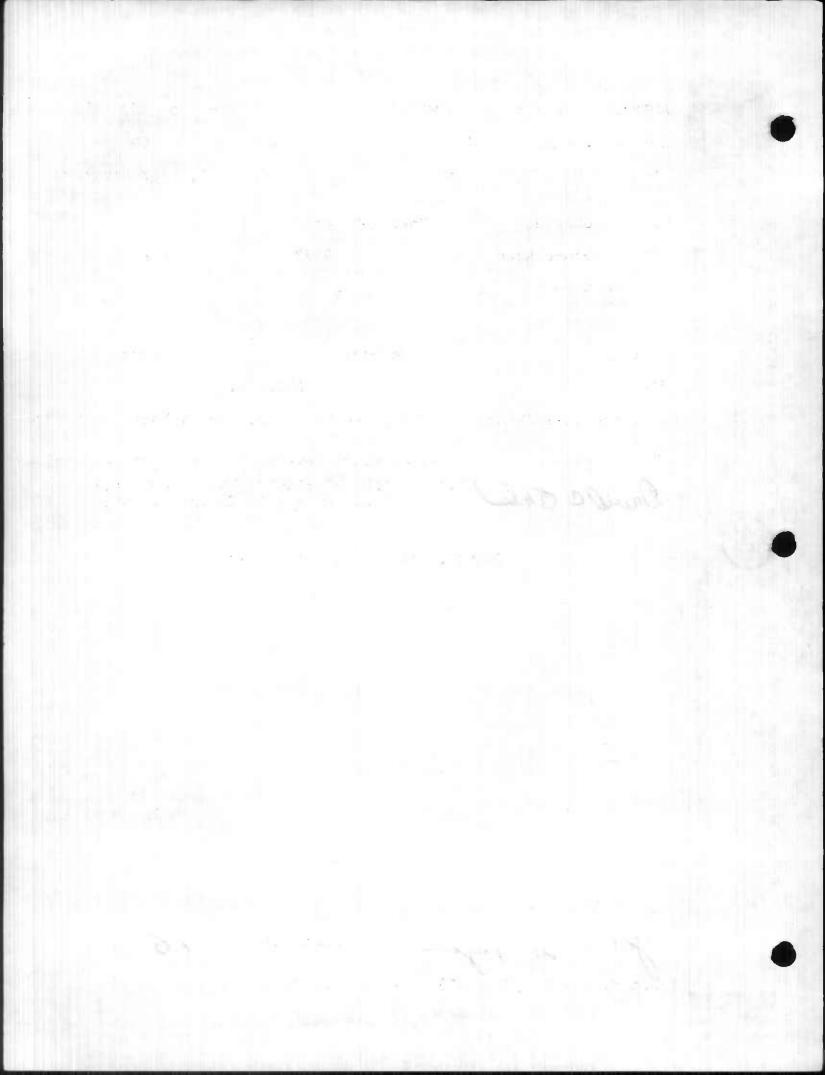
Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BOWMAN Month Physician FDNA AVGUST 1356 01 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS HOSPITAL BALTIMORE If Under 24 Hrs. 8 CITY If Under 1 Year Months Days Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) March 2, 1945 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2⊠ F Days Hours 219-42-8489 55 Yrs. Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or flams 23a or 25a-f abov the Medical Examiner must be notified at NE Yes 2□ No Worcester Snow Hill Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 404 Dighton Avenue 21863 U.S. Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merifel Stafus filed within 72 hours after 1 ☐ Yes 2 ☐ XÃio If Yes, Give Year or Detes: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Black by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12th the state Coilege (1-4or 5+) Certified Nursing Assistant Medical Facility 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Mental ed bluods Edward Davis, Jr. Rosetta Blue 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s mant of Health an # If Health Item 27 i Zelda Mathies/daughter 404 Dighton Avenue, Snow Hill, MD 21863 Baltimore, 20b. Piace of Disposition (Name of cemetery, cremetory or other place) important if its any injury or offi ance 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/5/00 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Cemetery Berlin, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee, Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death Physician hypotengian Immediate Cause (Final disease or condition resulting in death) /Medical two days Examiner Due to (or as e consequence of): Physician/Medical Examiner three days 509915 as the burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. attending physician Due to (or es a consequença of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 100 insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signed by respiratory ģ Records. 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Be Completed Gailure renal this certificate has 2 0 No 1 ☐ Yes 2 ☐ No 1 Tyes Division of Vital i or Attending Physician: after death. funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No Director: / 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1/ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number Jewlyn K Sect Medical Doctor August 01, 2000 P.ES. OCO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERLLYN SLOTT JOHNS HOPKINS HOSPITAL TOWER 110 DOLTOK'S LOWIGE 600 NURTH WOLFE STREET BALTIMGERS, MARYLAND 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State AUG 0 4 2000 Registrar

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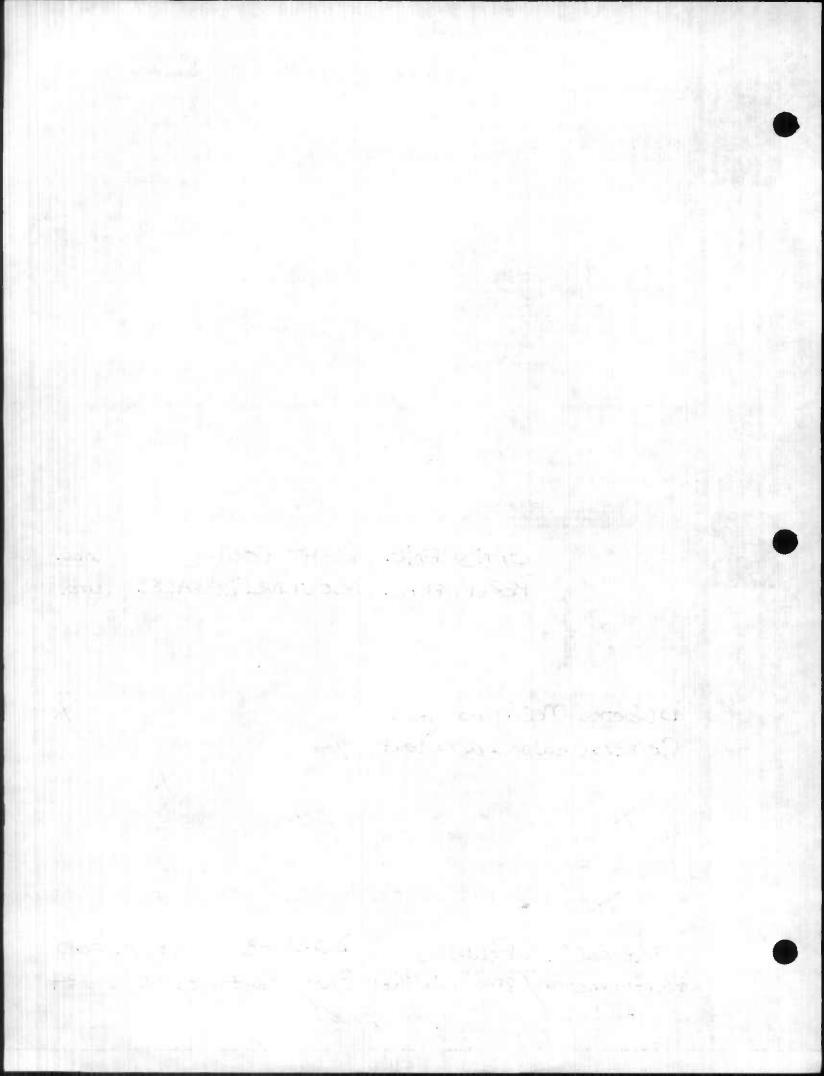
DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** LIONEL F. COWLEY August 9, 2000 1:55 a.m. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner OakCrest Care Center Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Deys Hours Yrs. 1919 81 July 5. Maryland Director 213-03-1958 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Baltimore Maruland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14 Juliet Lane, Unit 301 21236 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-M Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Yeer or Detes: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementery/Secondary (0-12) College (1-4or 5+) Pump Operator Balto. City Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Lionel O. Cowley Anna Brandt 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mark Cowley (Son) 12 Biscay Court. Baltimore, MD 21234 Saltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Pages 1 Burial 2 □ Cremetion 3 □ Removel from Stete Loudon Park Cemetery 08/11/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Buar Ce 9705 Belair Road, Baltimore, MD 21236 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immedieta Cause (Final disease or condition resulting in deeth) /Medical wks Examiner VASCULAR DISEASE Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In death) Lest Due to (or es a consequence of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by Records, 24a. Wes an autopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of death? erebrovosular accident 2 0 No 1 Yes 1 Yes 2 No of Vital 25. Wes case referred to medicel 26. Place of Deeth (Check only one) axaminer? s after death.

I Director: After this celed in by the funeral director. Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 8 Other (Specify) 27 Manner of Death 1 Naturel 2 Accident 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 5 Pending investigation 1 Yes 2 No 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 To the Hospital o within 24 hours at To the Funeral D 115 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner as stated.

2 Redical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29e. Certifier 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 1001 (Item 23a) (Type, Print) Walther Blud/ Baltmore 8800 State Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 0708 AM 2000 Mary Elizabeth Ciurca AUGUST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital If Undar 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year, **Funeral** Deys Hours 1□M 2♥ F 84 Yrs. 220-22-7821 Maryland Director Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show W Yas 2□No Directo Baltimore Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23s or the Wedital Examiner must be r 21206 U. S. A. 4310 Plainfield Avenue Funeral death Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, Biack, Whita, atc. 12. Wes Decedent Evar in U,S. Armed Forces? 72 hours efter 1 Yas 2 No If Yes, Give Yaer or Datas: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiena. 8th Grade Homemaker Own Home 7 is marked other 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Nem Z7 is marked oth any Injury or other traumatic even Pace. 17. Fether's Neme (First, Middle, Last) Stephen Adamski Mary Baylus 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Pinehurst Road, Ocean Pines, Maryland 21811 Joseph Ciurca (Son) 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremetion 3 Remo from State 18/9/00 Baltimore. Maryland 4 Donetion 5 Other (Specify) Sacred Heart of Jesus 21. Signature of Funeral Service Ligense Schumunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilura. List only one cause on each line. Onsat and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION 15 days Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): 68760, Physician/Medical Due to (or es e consequence of) Box P.O. 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 1 | Yes 2 | No. 3 Probably 4 Unknown by of Vital Records. 24b. Were autopsy findings aveilable prior to complation of causa of deeth? Completed 24a. Was an autopsy page 1 Yes 2 No 1 ☐ Yes 2 No i or Attending Physicien: after death. Be 25. Wes case referred to medice! examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To this 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No Director: / 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

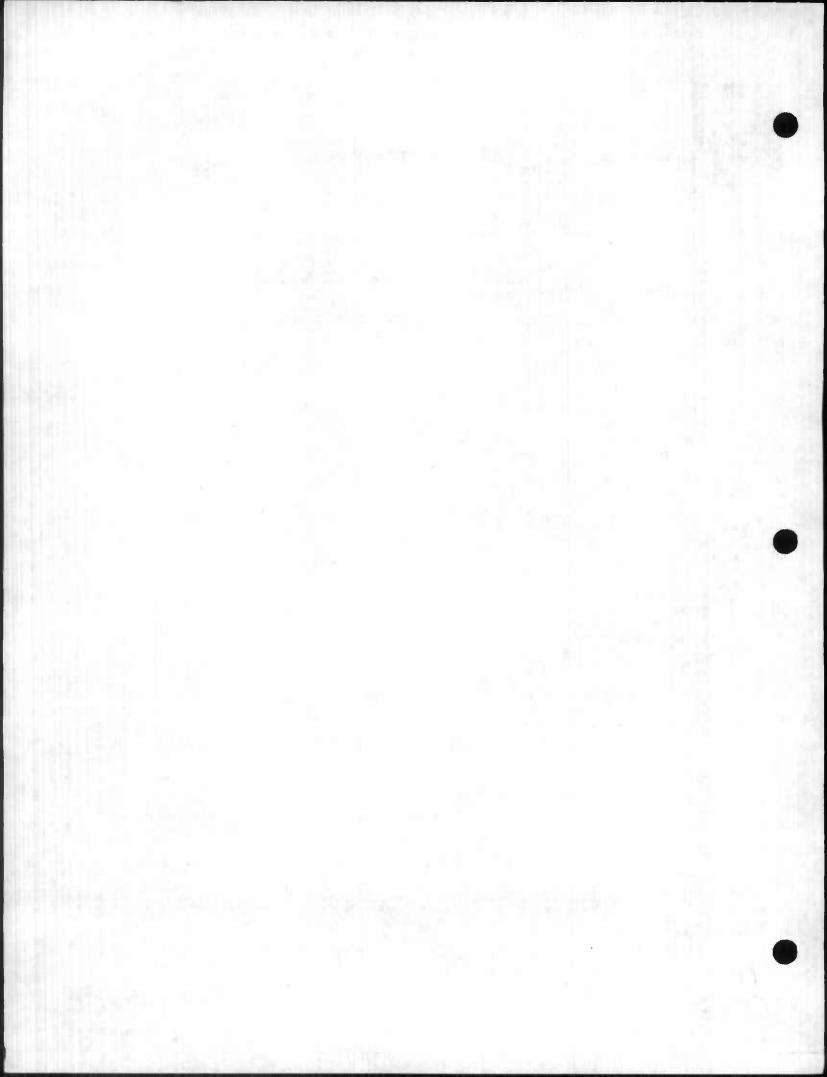
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier Taul MWH AT 2438946 AUGUST 7, 2000 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) PAUL M WOLF, MD 201 E. UNIVERSITY PKWY BALTIMORE, MD 31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

32. Registrar's Signeture

AUG 1 0 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Time of Death **Physician** AUGUST 6, 2000 Walter Kirk Cole 5:00 AM /Medical 4a Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 MM 2□ F Yirs 577-24-8157 77 Director 02/09/1923 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits Marvie 1 Yas 2 No Director MD 28s-f Cecil Port Deposit 2 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 "natural", or items 23s Wildwood Lane 21904 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc 1 X Yas 2 □ No If Yes, Give 1 Nevar Married 2 Merried 1 ☐ Yes 2 X No Specify: Specify: À White 3 ☐ Widowed 4 ☐ Divorced Year or Datas: WW2 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Welding Supervisor Shipyard Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Health and Mental James Cole 10 Mattie Wess important: if hem 27 is m any injury or other traum once. 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Cole- Wife 9 Wildwood Ln., Port Deposit, MD 21904 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Harford Memorial Gardns 8/10/00 Aberdeen, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. muth 123 S. Washington, Havre de Grace, MD 21078 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical PNEUMONIA 2 WEEKS Examiner Dua to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) CONGESTIVE HEART FAILURE physician the buria UNKNOWN Physician/Medical Dua to (or es a consequança of): 88 for use as Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS signed I by 24b. Were autopsy lindings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? BLADDER CARCINOMA page 2 CEREBROVASCULAR ACCIDENT 1 Yas 2X No 1 ☐ Yas 2 ☐ No certificate al or Attending Physician: The safer death.

I Director: After this certificated in by the funeral director, pages. Be 25. Was casa referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1X Netural 1 Yes 2 No invastigation 2 Accident 6 Could not be detarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital or 24 hours after Euroral Dieselv filled in letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

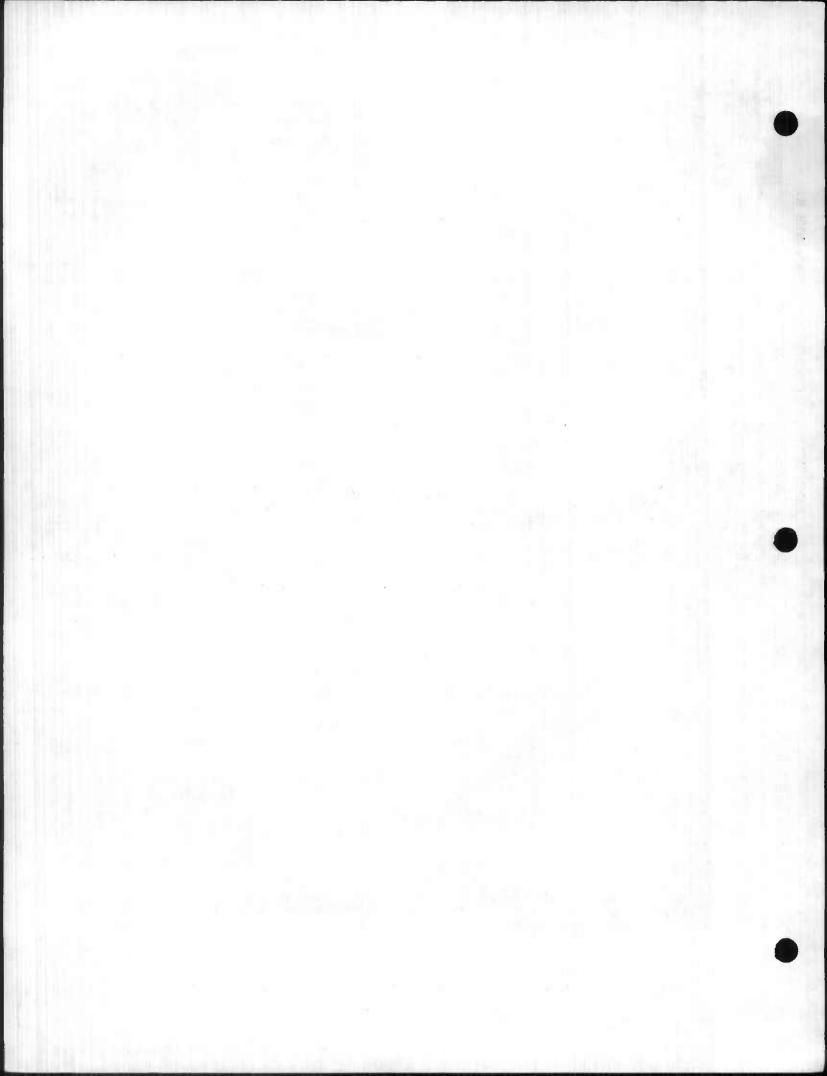
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Cartifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signetura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) Some Khew D0052064 AUGUST 6, 2000 30. Nema and address of person who completed causa of death (Item 23a) (Type, Print)

Registrar

SAMIR KHEIRI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND

31. Data filed (Month, Day, Year) State

32. Registrar's Signetura Knews AUG 8 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Daeth Month **Physician** 08 2000 9:33 AM Catherine Nora Chrismer /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death/ 4c. County of Deeth **Examiner** Med Conter Josepha Baltingere Baltinere If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) If Under 1 Yaer Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Hours Months 1 M 250 Director 214-14-7252 Usuel Residance of Decadent 86 Dec. 23, 1913 Maryland 10a. Stete 10b. Counts 10c. City, Town or Location 10d. Inside City Limits ortant: if Nem 27 is marked other than "natural", or items 23s or 28s-1 show injury or other traumatic event, "he Maxical Exerciner mass to not lised at XXYes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 219 West Hall Street 21014 12. Was Dacedant Ever in U,S. Armed Forcas? Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. 1 Navar Merried 2 Marriad 1 ☐ Yes 2\No If Yas, Give 1 ☐ Yea XXNo g n yas, Give Yaar or Datas: Specify: ₩idowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mentel Hygiere. Important: If Item 27 is marked other than "na any injury or other traumatic event, in Medic once. Elementery/Secondery (0-12) College (1-4or 5+) 2 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Melden Sumeme) Be James Alolysius Jordan Mary Catherine Lanahan 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Michael P. Chrismer - Son 6033 Blue Point Court, Clarksville, MD 21029 20e. Mathod of Disposition 20b. Placa of Disposition (Neme of cametery, crematory or other plece) Dete 20c. Location - City or Town, State 1⊠ Buriel 2 □ Cramation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Grdns. 8/7/00 Bel Air, Maryland 22. Nema and Address of Fecility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Mu 50 West Broadway, Bel Air, Maryland 21014 23a. Pert1. Emer the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one gruss on each lina. Approximate tntervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical minutes Examiner minutos Ventriaular Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in deeth) Lest Due to (or ea e consequence of): Kalemio attending physician for use as the buria per naus Physician/Medical Due to (or es e consequance of): nan 3 Agu Pert fl. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Insuther ence signed i Aq 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wea an autopay performed? Completed page 2 s nonar-8 1 Yea 2 PNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner?

1 Yea 2 No director. Be 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To funeral 27. Menner of Death 28c. Injury et Work? 26a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 I Homleide 1 Certifying Phyelcian: To the best of my knowledga, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier

P.O. Box 68760. Records, Division of Vital I or Attending Physician: after deeth. To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu

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certificate

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filed within 7 Hygiene.

Baltimore, Maryland 21215-0020

State Registrar 29b. Signatura and title of contino

29c. License number 4004825 29d. Data signed (Month, Dey Year) 2000

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MARK PO GLOTH 201

31. Dete filed (Month, Day, Year)

AUG 7 2000



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2000 Month **Physician** 0018 Rav Spencer Childress August 4, /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth Alig. 9, 1927 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Devs Hours 120 M 2□ F 72 Yrs Director 213-26-3002 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County 1 Yes XXNo Harford Aberdeen Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 3805 Aldino Road 21001 U.S.A. 238 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritel Stetus 18 Yes 2 No If Yes, Give Yeer or Dates: 1945–46 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ♣ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t6b. Kind oi Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Electrician Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be leafth and Mental Fred Childress Lucy Reep 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health reportant: If Nem 27 Jack L. Childress (Son) 718 Carsin Run Road, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Harford Memorial Gardens 8/8/00 Aberdeen, Maryland 21. Signature of Funeral Service Licenses Glubbe Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician s the burial Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Striknown 1 Yes 2 No þ Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parlormed? Be Completed 1□ Yes 2□No 1 Yes 2 Ne Vital 25. Was cese reierred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 NA edical Certification: To 1 1 Impalient 2 ER/Outpatient 3 DOA ō 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 BNatural 5 Pending Investigation Division or Attending Injury 1 Yes 2 No death. 2 Accident Director: 28i. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certife 29d. Dete signed (Month Day, Year) 12+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG ? Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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ral		Sex 7. As	ga (In yrs. last birt	hday) _ (rs.	If Under 1 Year Months Days			8. Data of Bir (Month, Da			olaca (State or Foreign
r	215-12-6536 Usual Residence of Decedent		77	113.				June 9	9,1923	Mar	ryland
	10a. State 10b. County		10c. City, Town	or Loc	ation			41.1		1	Od. Inside City Limits
6	Maryland Dorch	ester	Ca	mhr:	idge						1 Yas 200 No
Directo	10e. Street and Number	CDCCI		IIIOJI.	10f. Zip Code				10g. Citizen of V	What Cour	ntry?
				21613					US		
Funeral	110 Bayview Aven	12. Was Decedent	Ever in IIS				Prinin? (Sn				can Indian.
5	1 Nevar Married 2 Married	Armed Forcas	7	If Yes, specify Cuban, Mexican, Puarti			to Rican, etc.) Bleck, W				
by	₩Widowed 4 Divorced	1 ☐ Yes 🏋 🖫 If Yes, Give Year or Datas:		1	☐ Yes 2 No	o Specif	y:		Specify	. N	White
	15. Decedant's I	Educetion	16a.	Decede	ent's Usual Occ	upation			16b. Kind of Bu	usiness/Inc	dustry
plet	(Specify only highest g	rade complated) College (1-4or	5.1	(Give kind of work done during most of works life. DO NOT use retired)				ing	TMT 7		
Completed	11	College (1-40)	3+)	Н	omemaker				Own	n Hom	ne
Bec	17. Fathar's Name (First, Middle, Las	61)				18. Mot	her's Nam	e (First, Middle	, Meiden Sumer	10)	
0	Brice Abraham	Dean		Mary				Windson			
-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address (Stre				er, City or Town,	State, Zip	Code)
	Thomas Dean	Brother	3	058	3 Old F	ruitla	and R	oad Sal	lisbury,	Mary	land 21804
lant: If it	20a. Method of Disposition		20b. Placa of		ition (Name of atory or other p			Date	20c. Location -		
	1 Surial 2 Cremation 3 4 Donation 5 Other (Spec			_	n Cemet		1	8/13/00	Cam	bride	ge, Maryland
	21. Signature of Funeral Service Lie			7	Name and Add			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cari	0==0=	,o, .zz.j.zunc
	De Alange	ma			homas F						
	23a Pan Enter tha diseese, or co	molications that causa	d the death. Do n	7(00 Locus	st St	reet is cardiac	Cambric or respiratory	ige, Mar	yland	1 21613 Approximete
ian	anoth, or heart failure. List onl	y ona cause on each I	ine.								Interval Between Onset and Death
an	Immediate Cause (Final	0 0	CL		1.	.l.d			4.		4 2
er	diseasa or condition resulting in death)	a. End	Due to (or as a cosc leto hi	e c	Lyone	005 7	veriv	C 11010	any des	een	Jen
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Examiner		b. Arten	Due to (or as a c			cri	year.	<u></u>		- 1	7
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VMedicai	resulting in death) Last		204 (0 (0) 43 4 0	onooqu	01100 017.						
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To Be Completed by Physician	Part II. Other significant conditions	contributing to death h	out not resulting in	the un	deduing cause	niven In Par	11	23h Did	tobacco usa co	atributa t	o the cause of death?
hys	Tartii. Other arginicant conditions	contributing to death t	out not resulting in	010 011	oonying occord				ÞYes 2□No		bably 4 Unknown
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leted by Physicia	MOTE OF THE STREET							24a. Wa	s an autopsy	24b. W	Vere autopsy findings vailable prior to
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S	25. Was case referred to medical					80.51				11	1148 508000
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Ĭ.	1 Yes 2 Alo	1 Lympati	ent 2 ER/Ou		3LI DUA	401	Nursing H		how injury occur		(y)
ton	↑ Neturel 5 Pending	28a. Date of Inju (Month, Da	ay Year) II	njury	28c. in W	lork? ☐ Yes 21	□No				
competent rilled in by the luneral director, page z Medical Certification: To Be Comp	3 Sulcide 6 Could not	be Diese of te	jury - At home, fa	rm stre				28f. Location	(Street and Numi	ber or Run	al Route Number,
T	4 Homicide determine	building, e	c. (Specify)	1111, 5010	et, lactory, onle			City or To	wn, State)		
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	250. Orginatora and title of certifier	Elver .	. ^		100.000	29c. Licensa number					
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	30. Neme and address of person who	_							012	211	
	NOMAN THANK	29 500	AURORA	£	TREET	C	MMA	11066	141)	116	/3
State	31. Date filed (Month, Day, Year)	32. Regist	rar's Signeture	4	1						
gistrar	AUG 1120	JUU A	/	7.	done	1					

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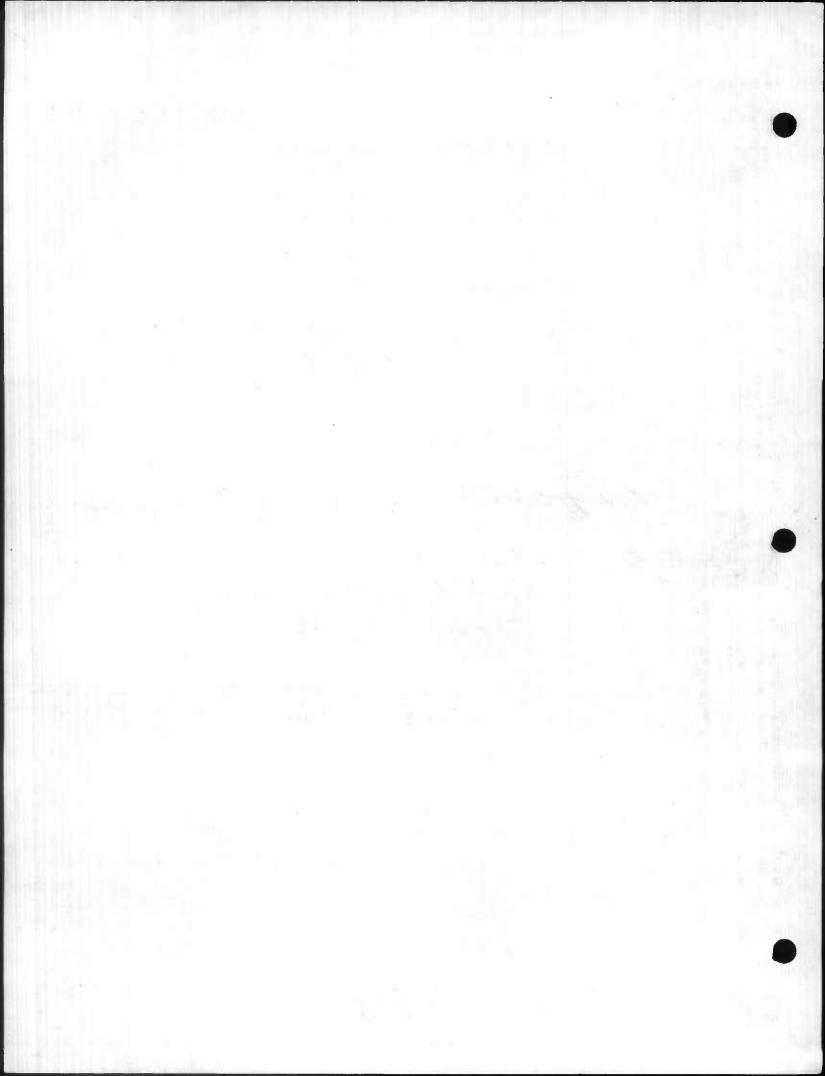
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Yes **Physician** Lelia E. Campher 09 2000 AUGUST /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTERN MARTLAND birthday) If Under r If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) HUSFITAL WASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sax **Funeral** Days 10M 20F Director 70 9782 WVA 216 22 Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Washington 1 Yes 2 No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Нета 23а 21740 39 Charles Street USA Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or hen any Injury or other traumatic event, the secondary. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Home maker Home maker 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Ernest Lewis Anna Russ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Hagerstown, MD 21740
Date 20c. Location - City or Town, State 39 Charles St., Oliver Campher (husband) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) B/15/00 Hagerstown, MD Rose Hill Cemetery 21. Signature of Funeral Service Licensus 22. Neme end Address of Fecility Watson Funeral Home Son 24. W. Bethel St. Hagerstown, MD

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21740 Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Ceuse (Finel disease or condition resulting in death) neumonia Examiner Due to (or as a consequence of) Examine physician and the bural-transit The law requires that the death certificata be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events betes Box 68760, by Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. and the signed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 has 1 Yes ≥ENo 1 □ Yes 2 □ No certificate Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural or Attending 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29e. Certifie (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and fittle of gertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 JAMESON PENNSLYVANI A AVE, HAGERSTOWN, MD AUG 1 4 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Craft Beatrice 05:24 August 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Center Beiltimore Cit Baltimore Medical If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 205 Months Director 221-16-7731 DELAWARE July 25 1927 **Usual Residence of Decedent** the Marylanx 10s. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits DELAWARE SUSSEX 1 Yas 2 No Director SEAFORD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 RT 2 BOX 54B 19973 herrs 23s AMERICA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② ☐ No if Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 3 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hyglens. other than 'n Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 10YRS. HOMEMAKER . Pages 1 and 2 should be flied w timent of Health and Mental Hygler tanti if Item 27 is marked other th jury or other traumatic event, Ith 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) Be WALTER PRETTYMAN JAMES DELEMA SAMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) GEORGE W. CRAFT RT 2 BOX 54B SEAFORD, DELAWARE 19973 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20s. Method of Disposition 20c. Location · City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8/11/00 OAK GROVE, DELAWARE BETHEL CEMETERY 21. Signature of F@ngra 22. Nama and Addrass of Facility WATSON-YATES FUNERAL HOME, INC. SEAFORD, DELAWARE 19973 236. Part1. Entil Do not entar tha mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Cause (Fina disease or condition resulting in death) Examiner Due to (or as a consec Examiner ician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buriel Box 68760. The lew requires that the death certificate be Physician/Medical Dua to (or as a consequence of): . 000 signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 □ Yas 2 No 3 Probably 4 Unknown of Vital Records. à 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? page 2 hes 2 ZNO 1 Yas 2 No or Attending Physicien: 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 1 funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Division deeth. 1 Yas 2 No n 24 hours effer deeth we Funeral Director: A plately filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Cortifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only od placa, and dua to the causa(s) \$ 29d. Data signed (Month, Day, Year) of death (Item 23a) (Type, Print) filed (Month, Day, Year) 32. Registrar's Signatura State AUG 0 9 2000

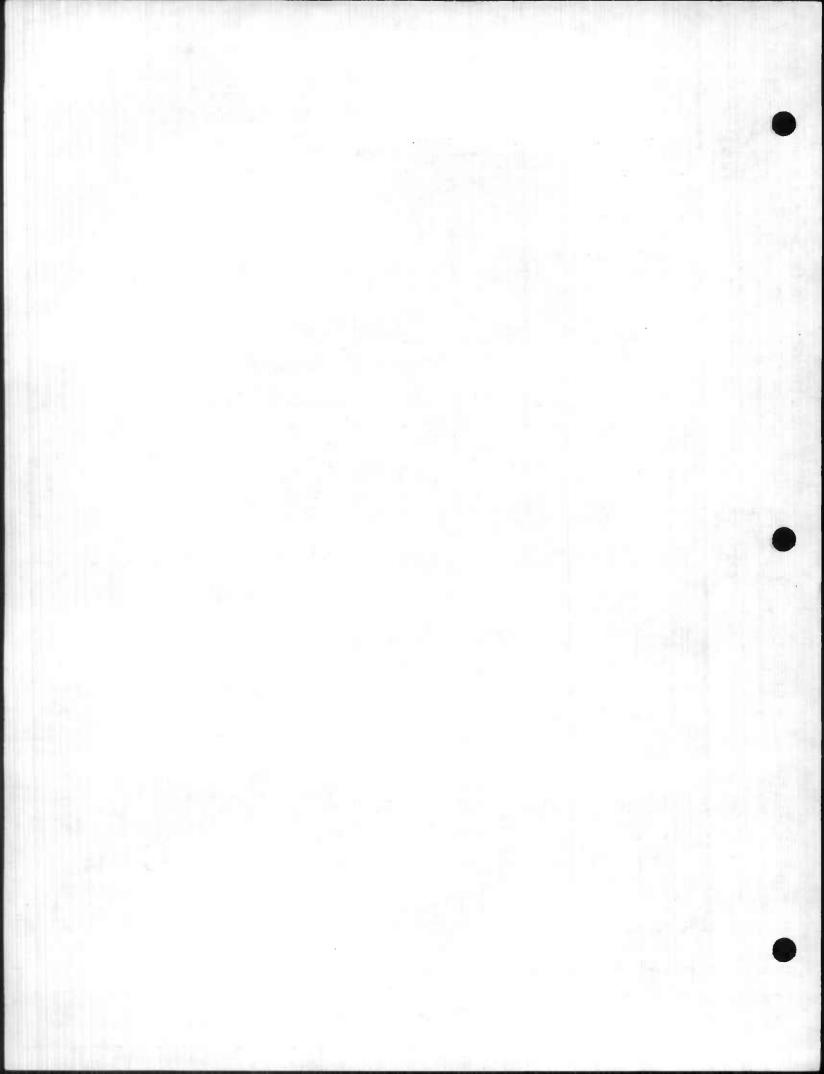
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Registrar

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Physici /Media	DACHET D	CIOCI			2. Dete of Dea Month Aug.	Day 7, 2000	Year 3: Time of Dea				
Examin	de Freilie Blane Mantinging of a standard and a selection			4b. City, Town, or Lo	cation of Death	4c. County	of Death				
	Salisbury Center; Genesis El			Salisbury		Wicor					
Funeral Director	5. Social Security Number 165-07-7468 Usuel Residence of Decedent	(In yrs. last birthday) 88 Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Dey SEPT • 9	Year) 1911	9. Birthplace (State or For Country) PENNSYLVANIA				
death with the Maryland ms 23e or 28ef show	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Li				
Me Maria	MARYLAND WORCESTER	BERLIN					1 🔀 Yes 2 🗆				
ê 9 ê	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Count					
ath v	1 MEADOW LANE, APT. 220		218			USA					
7 2 2 2	MARYLAND WORCESTER 10e. Street and Number 1 MEADOW LANE, APT. 220 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 1 Ves, Give Year or Dates:	If	Ves Decedent of I Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.				
LPA CI 15-002 172 hours "natural;	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usuel Occup	pation during most of worki	ing	16b. Kind of Bu	usiness/Industry				
KITS Within then then	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	life. D	ONOT use retire	d)		OWN H	OME				
DI Hyging	17. Father's Name (First, Middle, Last)		жыны	18. Mother's Neme	(First, Middle,						
RACHEL Maryland Ma 2 should be flightly and Mental Hy 17 is marked other traumatic event	WILLIAM BRANCA			UNKNO	WN						
RACHEL Maryla nd 2 should to the and Ment 27 is marked r traumatic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	end Number or Rura	al Route Numbe	, City or Town,	State, Zip Code)				
R.P. No. 1 and 1 st 1 and 1 st 1 and 1 st 1 and 1 st 1 st 1 st 1 st 1 st 1 st 1 st 1 s	ARLENE O. LINN/ NIECE			HWY., #50	7		MD 21842				
Baltimore, wmit. Pages 1 s Department of He montant: If them my injury or other materials.	20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Aother (Specify) ENTOMBMENT	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20b. Place of Disposition (Neme of cemetery, cremetory or other place)									
Balt permit Depart Import any in	21. Signature of Furreral Service Licenses 22. Name end Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975										
Physician	23a. PartT Enter the disease, or complications that caused in shock, or heart failure. List only one cause on part line	e deeth. Do not ente	or the mode of dyi	ng, such es cardiac d	or respiretory em	est,	Approximate Interval Between Onset and Deati				
/Medical Examiner	resulting in death)	ue to (or as e consequ		Ementiz	13-		yenres				
68760, licate be executed physicien and s the buriel-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	ue to (or as a consequ									
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P.O. at the d by the etachec	Part II. Other elgnificant conditions contributing to death but Report Di Sersse Sp	not resulting in the un	derlying cause gi	ven in Part i.		3b. Did tobacco use contributs to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unk					
Cords,	Completed by				24a. Wes a perfor		24b. Were autopsy finding available prior to completion of cause of death?				
f Vital Re- ysician: The lav sis centificate has director, page 2	E C				1 D Y	es MNo	1 ☐ Yes 2 ₹ No				
Vital F	25. Was case referred to medical			26. Piace of Deeth		-	12.00				
f V yaicle is cer direc	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA OI	her: Nursing Ho			er (Specify)				
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To the	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signe	d (Month, Day, Year)				
10	· Walle		D39	813		8/	16w-				
10 th	30. Neme and address of person who completed cause of dea	th (Item 23a) (Type, F	Print)								
10	MICHAEL ATKINS, M.D., 1104 HEA	ALTHWAY DR	SALTSP	URY, MD	21804						
Sta Registra	31. Date filed (Month, Dey, Year) 32. Registrar:	s Signature	Sparks		22001		l Me				

DHMH 16 Ray 6/95



MARTY CAY		I, II Certificate of										
Physician	Decedent's Name (First, Middle, Last) M	T	2. Date of D Month	Dey Year	3. Time of Death							
/Medical	Martin James Coy		AUGUS'		10:15A.M.							
Examiner	4a Facility Neme (If not institution, give street and number)	Car I										
Funeral	ATLANTIC OCEAN 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthdey) If Under 1 Yeer	OCEAN CITY If Under 24 Hrs. 8. Dete of B	WORCESTE 9. Bir	SK thplace (State or Foreign ountry)							
Director	452-70-6526 1 M 2 F 53 Usual Residence of Decedent	Yrs. Months Deys	Hours Min. (Month, L) July 1	1,1947 St.	Louis, MO.							
oth wif the Maryland 23s or 28s-1 show ust be notified at nai Director	10a. Stata 10b. County 10c	City, Town or Location		- Marie	10d. Inside City Limits 1 Yes 2/3/No							
or zta-fr be notifie	Maryland Prince George's 1	10f, Zip Code		10g. Citizen of What Co								
10 C					outiny !							
her death r hams 23 sher must	6804 Southfield Road 11. Meritel Stetus 12. Was Decedent Ever	20744 in U.S. 13. Was Decedent of H	lispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.)	USA lo- 14. Race - Ame	erican Indien,							
020 our after- af, or her Examiner	1 Never Married 2 Married Armed Forces? 1 Yes, Give 1 Widowed 4 Divorced Yeer or Detes: 19	cetired	an, Mexican, Puerto Rican, etc.) Specify:	Specify: Wh								
5-0 72 ho	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation	16b. Kind of Business	/Industry							
Maryland 21215-0020 d.2 should be fled within 72 hours at m. and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by 8	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Major USAF	daming most or working	Militar	y							
be med other	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle	le, Maiden Sumeme)								
riar Menta M	Martin James Coyne, Sr.	Virginia Fitz	gerald									
ary and N	19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street	end Number or Rural Route Num	ber, City or Town, State,	Zip Code)							
- 55667	Rita Coyne/Wife Same as item 10											
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Balti emit. epartm mports my inju	21. Signature of Funeral Servige Licensey	22. Name and Addre	ss of Facility									
m gossa	George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745											
6.	23ii Part. Enter the disease, or complications that caused the ock, or heert failure. List only one cause on each line.	deeth. Do not enter the mode of dyir	ng, such as cardiac or respiretory	arrest,	Approximete Interval Between							
Physician	117	TUDOL TON 1000	CIAMED LIMIT	DDOUNTNO	Onset and Death							
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)											
	resulting in deeth) Due to (or es e consequence of):											
68760, ceta be executed physician and s the burial-transit	Sequentially list conditions, If eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events Due to (or es e consequence of): Due to (or es e consequence of):											
O 5 7 0	resulting in death) Last											
Geath death death death	Pert II. Other significant conditions contributing to death but no	t resulting in the underlying cause (ii)	ren in Pert I 23h. Di	d tobacco use contribut	te to the cause of death?							
P.O.	ARTERIOSCLEROTIC CARDIO		23b. Did tobacco use contribute to the 1 Yes 2 No 3 Probable									
Il Records, The law requires the has been signe page 2 should be completed by				as en eutopsy formed?	Were autopsy findings available prior to completion of cause of death?							
The lay ate has page 2			. 10	Hes 2□No	1 No 2□ No							
Vital I	25. Was case referred to medical		26. Place of Deeth (Check only	y one)								
	examiner? 1XX es 2 No Hospitel: 1 Inpatient	2 ER/Outpetient 3 DOA Oth	ner: 4 Nursing Home 5 Re	sidence 6 DOther (Sp	ecity) OCEAN							
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District of in Below	4 Homicide building, etc. (St	ATLANTIC C			n city, MD.							
Hospi 24 hou Funer Funer stely fill	29a. Certifier (Check only (Ch	knowledge, death occurred at the timinetion end/or investigation, in my o	me, date and place, and due to the pinion, death occurred et the time	e cause(s) and manner a e, date and plece, end du	s stated. se to the ceuse(s)							
To the comple	290. Styllature and title of optifier	29c. Licens	e number	29d. Date signed (Mor	nth, Dey, Year)							
	(Carbolew)		C.M.E.	AUGUST 6,20	000							
	30 Name and address of person who completed cause of deeth Technology Williams and State of the state of the		Street, Baltim	ore, Marylan	nd 21201							
State	31. Dete filed (Month, Dey, Year) 32. Registrar's S		6									
Registrar	AUG 2 4 2000 Dene	1- /-										

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per phys. G786 8.24/00 yf Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** June 8 2000 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hra. Hours | Min. Birthplaca (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Deys MM 20 F 215-72-3488 Usual Residence of Dacedeni Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 No Funeral Director INCESS ANNE Md. Somer set 10g. Citizen of Whet Country? 10e. Street and Number 2/85 USA) 14. Race - American Indian, Black, Whita, etc. HARR 238 Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puarto Rican, etc.) or Nema 11, Merital Status Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: B/9CK Be Completed by Yeer or Dates 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17, Fathar's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental raige CONQUEST 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of Cometery, cremetory, cremetory or other place) Serena or other tree CONQUEST- Wite 20a. Method of Disposition Burial 2 Cremation 3 Removal from Stete 6-17-00 Atlantic, NA Wharton Foneval Home 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardio shock, or heart failure. List only one cause on each line. Samuel 22171 Wharton Rd. Accomac, VA 2339 Approximata Intervel Between Onsel and Daath Physician Immediate Cause (Finel disease or condition rasulting in death) Me lical 2 weeks phreumunia exar liner Due to (or es e consequence of): METASTATIC CARCINOMA LUNG Physician/Medical Examiner Sequentielly list conditions, if any, leading to Immedieta cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Last Due to (or as a consequence of) Box 68760 Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by Division of Vital Records. 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 Yas 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28b. Tima of 28d. Describe how Injury occurred Neturel 5 Pending 1 ☐ Yes 2 ☐ No invastigation after death. 2 Accident Director 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral Dicompletally filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and dua to the cause(s) and menner stated. Medical 29e. Certifier 29b. Signature end title of milities 29c. License number 29d. Date signed (Month, Day, Year) 00 D 70853

Registrar

72-

ess of person who completed cause of death (Item 23a) (Type, Print)

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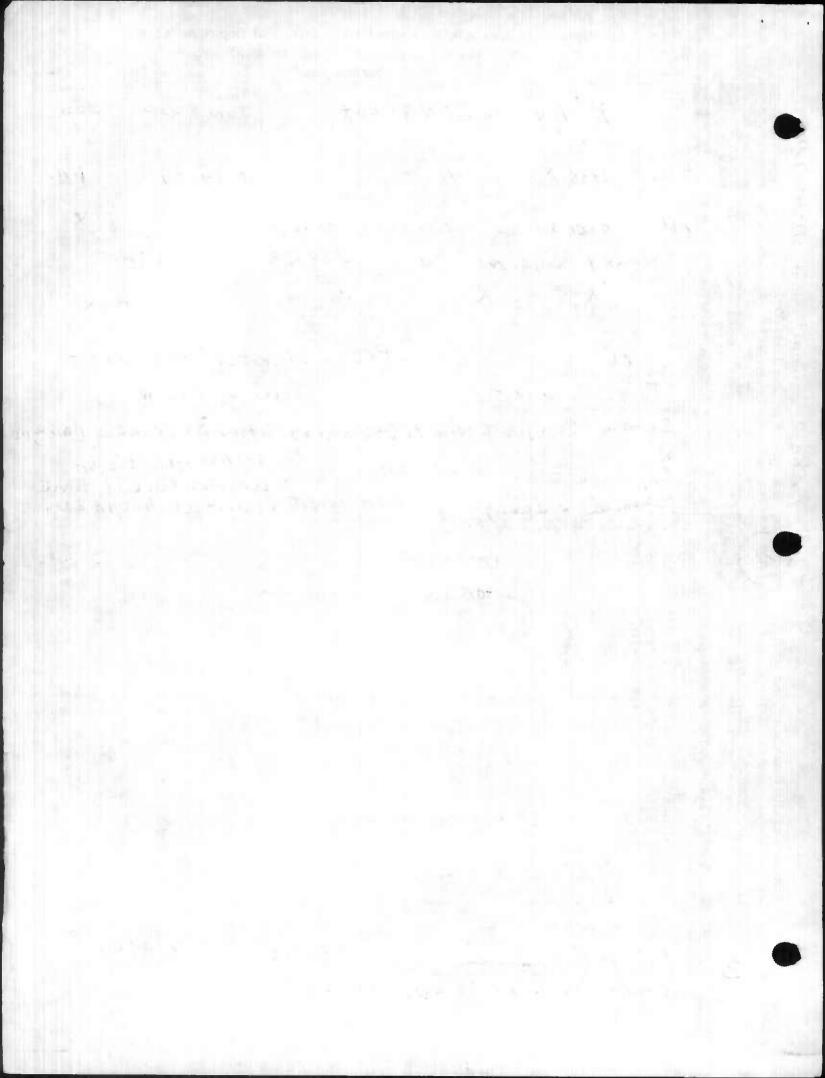
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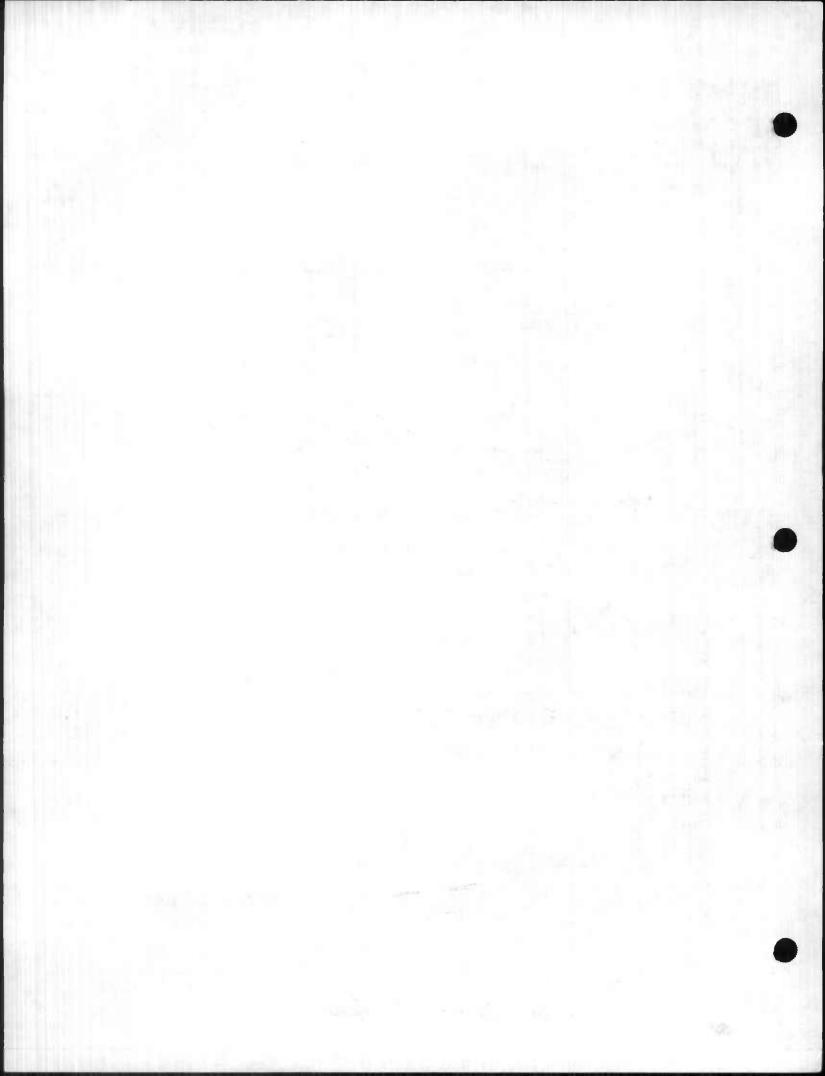


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

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Fune Direc		5. Social Security 219 20 4	096	Sex 1□M XXF	7. Age (In 75	yrs. last birthday) Yrs.	Months Da		s. 8. Date of B (Month, D April	8, 1925	9. Birthplace (State or Foreign Country) Maryland	
B 8:	12	Usual Rasidence	10b. County		10c. City, Town or Location						10d. Inside City Limits	
ith the Maryland or 28a-f show	to to	MD	Washin	gton		Hancock					XM Yes 2□ No	
9 De 29	Director	10e. Street and No			10f. Zip Code				10g. Citizen of	What Country?		
aff w 23a	ra le	106 Fr	anklin S	treet			217		DAL F.M	U.S.	Α.	
5-0020 72 hours affer death with the Maryla netural", or fleme 23s or 28s-f show	by Funeral		rried 2 Married	Armed F	Ves Decedent Ever in U.S. Immed Forces 2 \(\)				Specify Yes or N rto Rican, etc.)	lo- 14. Ra Bla Speci	ca - American Indian, ack, White, etc. White	
2 hou	tod	10	15. Decedent's I	Education		16a. Dece	dent's Usual Oc	cupation	-42	16b. Kind of E	Business/Industry	
Maryland 21215-0020 02 should be filed within 72 hours all th and Mental Hygians. 7 is marked other than "netural", or	Completed	Elementary/Sec 12	condary (0-12)		(1-4or 5+)	life.	DO NOT use re		orking	Re	etail	
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y in	To To	James		Ralei	gh	Myeı		Mary	Magde		Coffman	
CHRI	and and	Sharon I	lame/Relationship			8845	19b. Mailing Address (Street and Number or Rural Re 8845 Signal Drive, Willi			ort, MD	21795	
Deliumore, semit. Pages 1 a Separtment of Hea mportant. If Nem	lary or off	20a. Method of Dis 1 Buriai 2 4 Donation	sposition Cremation 3 Under (Spec	□Removei from	stete S	tone Breth	ren Cen	fich of setery	Date // 12/200	↓ O Hanc	- City or Town, State	
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Physic	ian	23a. Part1. Erher shock, or he	the disease, or col art failure. List onl	mplications that y one cause on	caused the each line.			dying, such as cardi			Approximate Interval Between Onset and Death	
/Medi Examir	ner	Immediete Cause disease or conditi resulting in death)	on	Cere	The state of the s	scular A					3 weeks	
o. executed an and	Examiner	Sequentially list of	equentially list conditions, Bue to (or as a consequence of):									
ifficate be ex	dicai E	if any, leading to i cause. Enter Und Cause (Disease of that initiated even resulting in death)	is T	c	Due t	o (or as a consec	quence of):					
es that the death certificate be as igned by the attending physician	be detached for usa as the but by Physician/Medical			d	d							
d by the a	ysic	Part II. Other algn	ficant conditions	contributing to	death but not	resulting in the u	inderlying cause	given in Part I.	23b. Die	d tobacco use c	ontribute to the cause of deeth?	
that the ded by	y Ph	Transver	se Myeli	tis with	h quad	riplegia	a e		10	Yes 2 No	3∑ Probably 4 Unknown	
v requir	leted	Hyperten	sion						24a. Wa	s an eutopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?	
certificate has	Completed	Hypothyr								Yes 2 No	1 Yes 2 No	
sicia certi	To Be	25. Was case refe axaminer? 1 ☐ Yes 2 ☑	No	Hospital:	Inpatient	2 DER/Outpatie	3 DOA	Other	Home 5 Per	sidence 6 🗆 Ot	has (Snacihi)	
Attending Physician: or death:	ation: T	27. Mannar of Dea 1 Natural 2 Accidant		28a. Data (Moi		28b. Time o	f 28c. t	njury at Work?	1	how injury occu		
or Attending la or Attending la or Attendent.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not detarmine	28a. Plac	e of Injury - / ding, etc. (Sp	At home, farm, streetly)	reet, factory, offi	СВ		(Street and Num own, State)	ber or Rural Routa Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has complaint filled in but the funeral Infrarent process.	edicai C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and man 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and man and manner stated.										
To th	Me	29b. Signature en	titie of cartifier	,			29c. Lic	ense number		29d. Date sign	ed (Month, Day, Year)	
			100	~/-	3,		D34	165		August	9, 2000	
		30. Name and add Mohammed	rass of person who		use of death (Item 23a) (Type,	1.00	Pennsylvani rstown, MD 2				
Reg	State gistrar	31. Date filed (Moi	AUG 1 Q 2		Registrar's S	ignature &	Span	Ks	14			



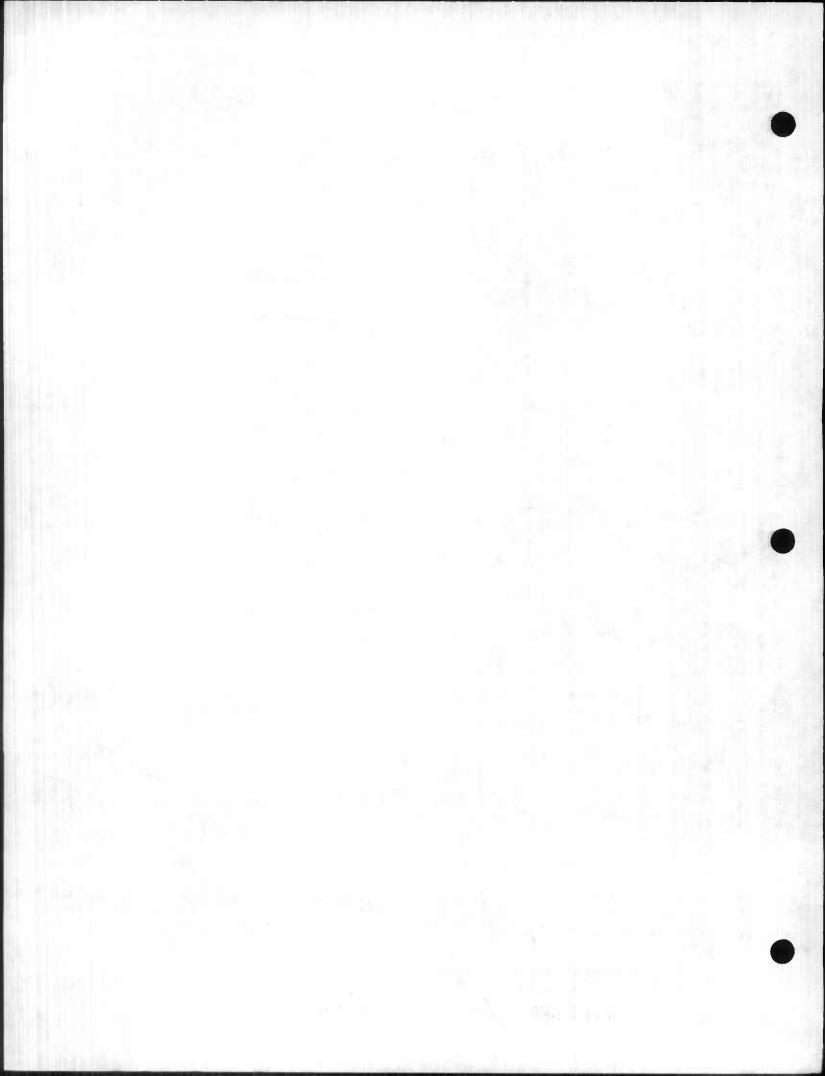
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** august 13 2000 Konald Gasterda 2:30 pm /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. Month, Day, OCt. 5, Washington (oundy Washington Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 12 M 2□ F 213-40-4797 56 Yrs. Maryland Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits r 28a-f show unplified at Washington Co. MD Boonsboro 1 Tyes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21450 Greenbrier Road 21713 U.S.A. natural, or itsme 23a Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☒No
If Yes, Give
Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 1□ Yes 2 No à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Self employed Brick Mason 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important: If Item 27 is marked any injury or other 27 is marked other. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Granville T. Easterday Ruth Toms 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Darlene M. Easterday/Wife 21450 Greenbrier Road, Boonsboro, MD 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata Date 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Aug.17 Boonsboro, Maryland Boonsboro Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme and Address of Facility
Douglas A. Fiery Funeral Home
1331 Fastern Blvd., N., Hagerstown, Maryland 21742 21. Signeture of Funeral Service Licensee 23a Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heer failure. List only one ceuse on eech line. Approximete Intervel Betw Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Lung Cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributs to the cause of death? been signed by t should be detack 1 Naa 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Yes 3 No 1 ☐ Yes 2 0 No of Vital 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1. Impatient 27. Menner of Deeth 28d. Describe how injury occurred Injury at Work? 1 Neturel 5 Pending Injury 1 Yes 2 No 2 Accident investigation 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in the Funeral D completely filled in the Funeral D completely filled in the Funeral D completely filled in the funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and pleca, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier D50813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ans 12d Suit 127 Haguton My 21742 OMalley 11110 Medical MI 32. Registrer's Signeture AUG 1 5 2000 31. Dete filed (Month. State Registrar

Ronald

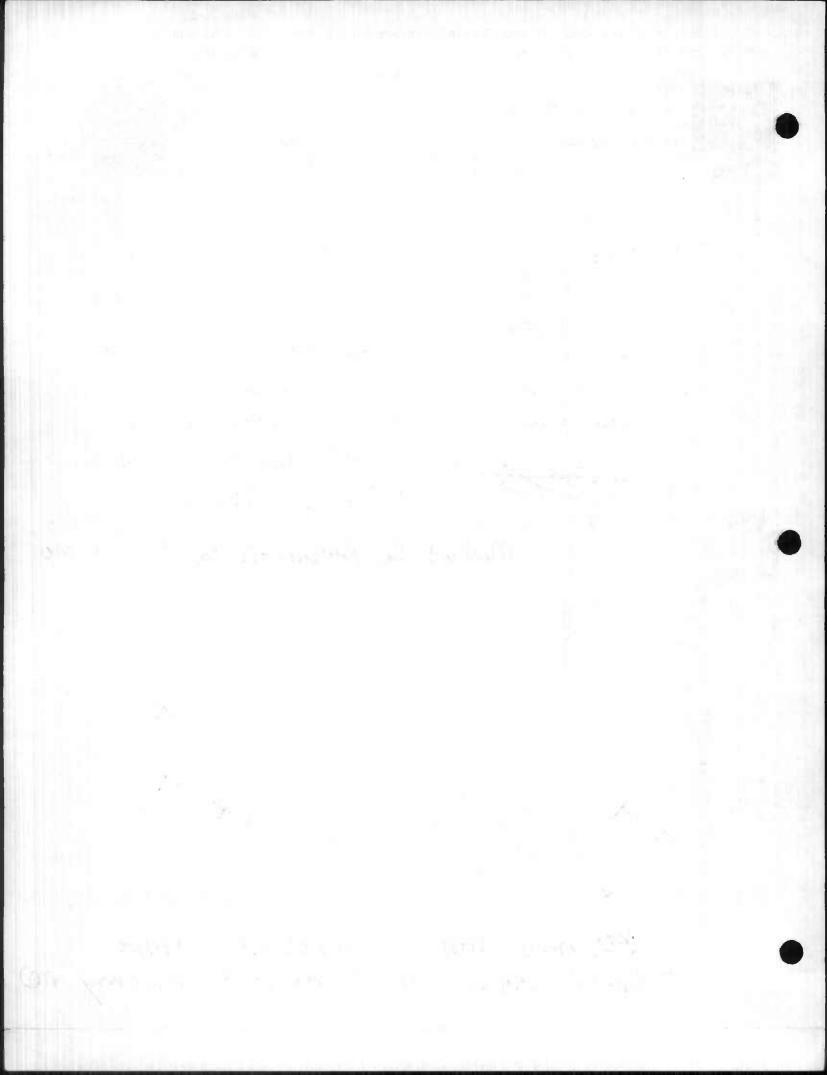
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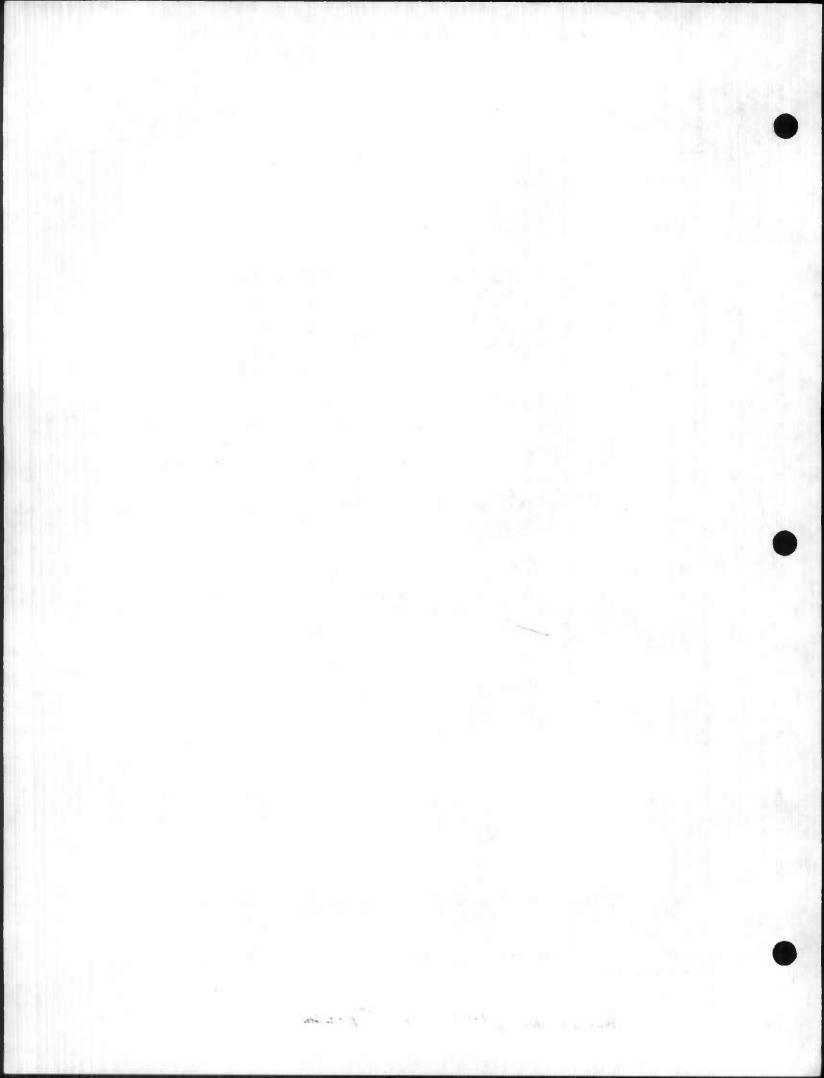
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Dharaiaia		1. Decedent's Nemo	e (First, Middle, La	ist)							2. Dele of De		Veer	3. Time	of Deel
Physiciar /Medica		Pauline	Elizabe	th Ennis	5						August	03	2000	11:0	0 A
Examine	_	4a. Fecility Neme (II	f not institution, giv	e street and nun	nber)			41	b. City, To	wn, or Lo	cation of Deeth	4c. Count	y of Deeth		
	Ц.		sey Road						Salis	-			omico		
Funeral Director		5. Sociel Security N 213-24-48 Usuel Residence of	16	Sex 1□M 252 F	7. Age (In yrs. 71	lest birthday) Yrs.		Year Pays	Hours	24 Hrs. Min.	8. Dete of Bir (Month, De Sept 7	y, Year) 1928	9. Birthi Cou	plece (State ntry) MD	or Fo
show		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside	City Li
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"natural",	Completed		15. Decadent's E	ade completed)		(Give	16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)			of work	ing	16b. Kind of I	3usiness/In	dustry	
jens.	E	Elementary/Second	ndary (0-12)	College (1-	-4or 5+)		Receivi			n		Month ugust 03 2000 11:00 AM ion of Deeth Wicomico Dete of Birth (Month, Dey, Year) ept 7, 1928 9. Birthplece (State or Foreign Country) and the first of the country? Ind. Inside City Limits 1 □ Yes 2 ⋈ No. 10g. Citizen of Whet Country? U.S. Yes or No- 14. Rece - American Indien, Bleck, White, etc. Specify: Black 16b. Kind of Business/Industry Food irst, Middle, Meiden Sumeme) Cornish Courte Number, City or Town, Stete, Zip Code) bury, MD 21801 Dete 20c. Location - City or Town, Stete /00 Salisbury, MD al Home ury, MD 21801 papiretory arrest, Approximate inlevel Between Conset end Deeth Game 23b. Did tobacco use contribute to the cause of death			
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and Mental I	m													1	
M M			Thomas Elzey, Sr. Mary F rment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Ru							4				o Code)	
trau	Elmer R. Ennis/husband 1908 Jersey Road											, , ,			
Hee	-	20a. Method of Disp			20b. P	Plece of Dispo	osition (Neme	of	Dete 20c Location - City or Town 5				own, Stete	-	
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Dependimporting any in		21. Signeture (Fig.	nami Separati	1		Le		Wa	tson	Fune					
	-	02a Bartt Fater th	a disease as seen			116	18 Wes	t R	d., S	Salis	sburv.	MD 2180	1		
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State of Maryland / Department of Health and Mental Hygiene

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ELIZABETH	FREBURGER			Cei	tificate of	Death		F	Reg. No.	00	60360	
	1. Decedent'a Name (First, Middle,	Last)						2. Date of Dea		Vece	3. Tima of Death	
Physician	ELIZABETH ETHEL	FREBURG	ER					Month AUG.	8, 200	Year	10:03 AN	
/Medical	4a Facility Name (If not institution,					4b. City, To	wn, or Loc	ation of Death			10.03 A	
Examiner	FALLSTON GEN					FAT.	LSTON			FORD		
Survey 1			7. Age (In yrs.	last birthday)	If Under 1 Yea			8. Date of Birth (Month, Day			place (State or Foreign	
Funeral Director	212-40-3225	1□M 20XF	58	Yrs.	Months Day	s Hours	Min.	Feb. 5	1942	Mai	place (State or Foreign http:/ LYLand	
Director	Usual Residence of Decedent							100. 5	, 1/12	1.100	cycarra	
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or 25s-f s or 25s-f s be notified Directo	10e. Street and Number	rui .	be	i mi	10f. Zip Code			10g. Citizen of What Countr			ntry?	
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ther death of the same the same same same same same same same sam	2116 Cypress Dr		edent Ever in U	S 13	Was Decedent of	ioin? (Snec	ify Yes or No-			can Indian,		
S PR	11. Marital Status	Armed Fo	rces?	10.	f Yes, specify Cu	ban, Mexical	n, Puerto R	lican, etc.)		k, White,		
fr. or in all	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes If Yes, Giv Year or D	e		1□ Yes 2♥ No	o Specify:			Specify	r: 1	Vhite	
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2000	20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3	□ Removel from		Plece of Dispo cemetery, crei	sition (Name of natory or other p	lace)		Date	20c. Location -	City or To	wn, State	
Pag	4 Donation 5 Other (Spe		Sac	red He	art of -	Jesus 1	Cem. 8	/12/00	Baltin	nore,	Maryland	
1227	21. Signature of Funeral Service Lic	ensee			. Name and Add					1-11		
FOLER	Buan a Wellem Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014											
Physician	23a. Part 1. Enter the disease, or co	malications that o	aurad the deat	b Do not on	IU W. MC	icrnai	K KOA	a, Be	c AUI, I	MD 2	Approximate	
	shock, or heart failure. List or	ly one cause on e	ach line.								Interval Between Onset and Death	
ding physician and is as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		vene		uence of): hrombos juence of):		· low	ver ex	rtremit	x		
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	Part II. Other significant conditions	contributing to de	MILLI DOL HOL 195	utting in the u	noenying cause (given in Fent			Yes 22 No		bably 4 Unknow	
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yelclen: The secutificate director, pag	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only o	ne)			
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Atte	3 Suicide 6 Could no determine	28e. Piece	of Injury - At h	ome, ferm, st	eet, factory, offic	0	2	8f. Location (S City or Tov		ber or Rui	ral Route Number,	
tal or Attending P rs after death. al Director: After t led in by the funera Certification:	4 Homicide	Dullal	ng, etc. (Specif	(y)				City of 100	III, SIAIO)			
To the Hospital or Attending Phythip 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral Medical Certification:	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Phyetcian: To the arminer: On the brand man	best of my kno asis of examine ner steted.	owledge, deat etion end/or in	n occurred at the vestigation, in my	tima, date ar y opinion, dea	nd place, e ath occurre	nd due to the	cause(s) and m date and place,	anner as	stated. to the cause(s)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Irwin Scott Fears August 05 2000 8:50am /Medical 4a Facility Name (If not Institution, giva street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Havre de Grace 148 Bloomsbury Ave. Harford If Under 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 10XM 20 F Davs 10/21/1916 Director 216-12-8000 83 Maryland Usual Residence of Decedent the Marylend 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 28a-f ehow 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 148 Bloomsbury Avenue 21078 deeth 12. Was Decedant Evar in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on end Mental Hygiena.

Is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: λq Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th Supply Officer Government 18. Mother's Name (First, Middle, Maidan Surnama) 17. Fathar's Name (First, Middla, Last) Pages 1 and 2 should be fit ment of Health end Mental H and: If Item 27 Is marked out Joseph Scott Fears Beulah Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Fears- Wife 148 Bloomsbury Ave., Havre de Grace, MD 21078 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from Stata Department of Important: If any injury or 20 8/9/00 | Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Médical Immediate Cause (Finel disaase or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): pue bunal-tran physician Physiclan/Medical the Due to (or as a consequence of): 88 980 jo ed by the a 23b. Did tobacco use contributa/to the cause of death? P.0. Part II, Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 probably 4 Unknown 1 Yss 2 No signed b py Records, 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy Completed peen page 2 2000 1 □ Yes 2 □ No 1 TAVES certificata Division of Vital Attending Physician: director 25. Was cese referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 8 Other (Specify) 1 Yes NO No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mapher of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: After Injury Netural 5 Pending offer death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Coald not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely To the Vithin 2 29c. License numb 29d. Date sigged (Month, Day, Year) 29b. Signature and title of certifier ς

32/Ragistrar's Signatura

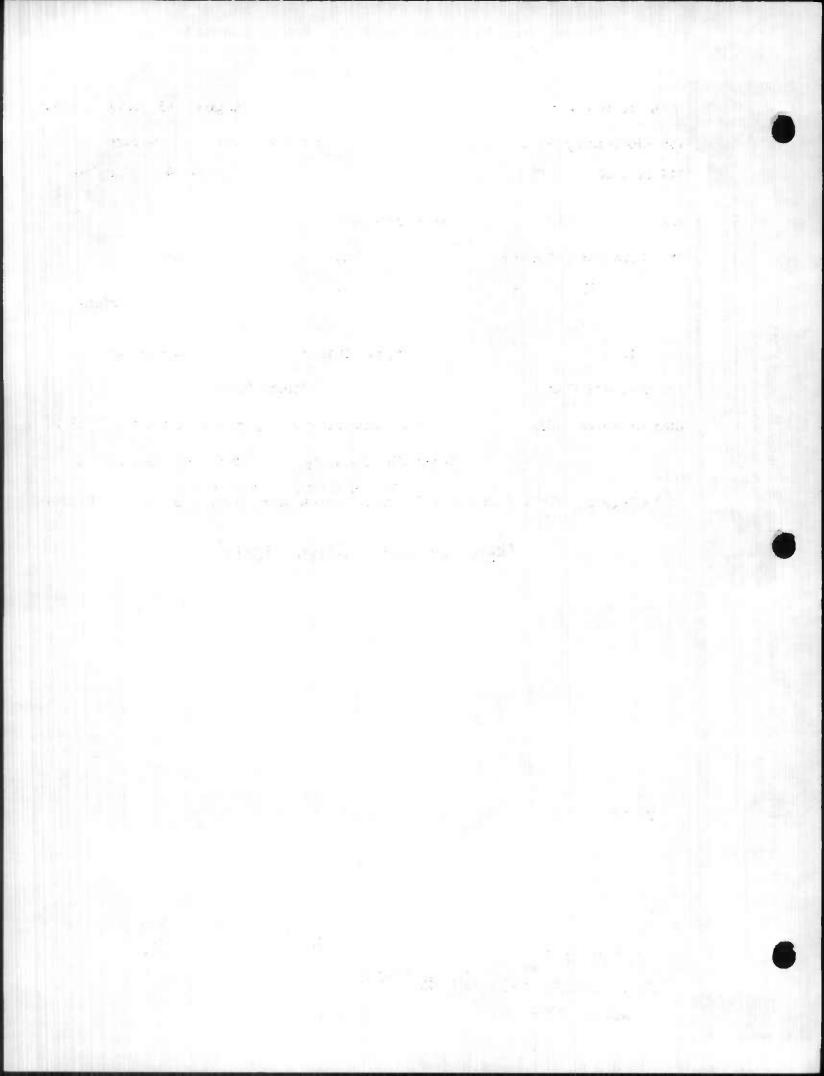
State Registrar 3

31. Date filed (Month, Dey,

AUG 8

2000

DHMH 16 Rev 6/95



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nsme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 00 26 A.M. August 08 EDWARD LEONARD GITTINGS 2000 4b. City, Town, or Location of Death 4a Fscility Neme (If not institution, give street end number) 4c. County of Death Fallston General Hospital Fallston Harford H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) if Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months 1MM 2□ F 82 215-12-3240 29/1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Harford MD. Joppa 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21085 1401 Lake Vista Drive U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 8 Self employed Retail Liqueur Sales 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Gittings Albert Matilda Swagler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2]084 19a. Informant's Name/Ralationship (Type, Print) Edward L. Gittings Jr./Son 1607 Cynthia Court Jarrettsville, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland lighview Mem. Garden, 2000 21. Signature of Funaral Service Licensie 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intarval Between Onset and Death tmmediate Cause (Finat Houng disease or condition rasulting in death) levo te Sequantially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 Probably 4 Unknown 1 Yss 2 No 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 ☐ Yes 2 ☐ No

Examiner Box 68760. P.O. Records,

Physician

/Medical

Examiner

Directo

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Funeral

Director

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permit. Pages 1 and 2 should be till.
Department of Health and Mental Hy
important: If Item 27 is manked oth
any injury or other traumadic even

Physician /Medical

Maryland

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Examiner Physician/Medical Completed Attending Physician: Be Certification: To this after death. Director: Af 124 hours after the Funeral Direct colorates filled in b 6

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25. Was casa referred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 Sinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 27. Mannar of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29c. License number

FACE

Gretrar's Signature

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who completed cause of death (Item 23a) (Type, Print)

and. Date signed (Month, Day, Year)

State

Registrar

DHMH 16 Rev 6/95

To the Hosp within 24 hor To the Fune completely fi

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Neme (First, Middla, Last) 2. Dete of Deeth Month Yaar RUTH E. GREENE Aug. 8,2000 1:45 PM 4e. Fecility Name (If not institution, give streat and number) 4b. City. Town, or Location of Deeth 4c. County of Death BA1timore Future Care Old Court Randallstown 8. Deta of Birth (Month, Dey, Year) 5. Social Security Number It Under 1 Year if Undar 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) Deys 1 M 3/3/F Yrs. 92 8/8/1908 215-76-1977 Ohio 10h County 10c. City. Town or Location 10d. Inside City Limits Harford 1552 MAin St. 1 Yas 2KINo Whiteford 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1552 Main Street 21160 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ※® No if Yes, Give Yeer or Detas: Wes Decedent of Hispanic Origin? (Specify Yes or Notit Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Raca - American Indien, Bieck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X Xo Specify: Specify.White 3 Widowed 4 12 Mivorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Retail Clerk 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Unknown Unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1552 Main St., Whiteford, MD 21160 Dean C. Greene - son 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Wurlal 2 Cremetion 3 Removel from State Jarrettsville Cemetery 8/11/00 JArrettsville 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Harkins F.H. Inc., 600 Main St., Delta, PA 17314 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiretory errest, or heart teilure. List only one cause on each line. Approximeta Interval Between Onsal and Deeth Immediete Ceuse (Final AlzhEIMER'S diseese or condition resulting in daeth) Due to (or as e consequança ot) Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Due to (or es a consequence ot) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes an eutopsy performed? 24b. Were autopsy tindings avelleble prior to completion of causa of death? 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical 26. Piece of Deeth (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

Director

Funeral

Completed by

Be

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

filed within 72 hours after

Hygiena.

merked other 7 is marked other traumatic event,

. Pages 1 and 2 should be fill iment of Health and Mental Heart: If item 27 is marked oth lury or other traumatic even

Department of Important: If any injury or

21215-0020

Baltimore, Maryland

the burial-tran USB as signed by this certificata has director, nous after death.

The law requires that the death cartificate be axecuted

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner by Completed Be 2

Certification:

To the Hospital of within 24 hours at To the Funeral D Medical

> State Registrar

29b. Signature and title of certifier

27. Manper of Deeth

Naturel

2 Accident 3 Suicide

4 Homicide

(Check only onel

29a. Certifier

5 Pending Investigation 6 Could not be determined

28a. Dete of Injury (Month, Day Year)

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

28d. Dascribe how Injury occurred

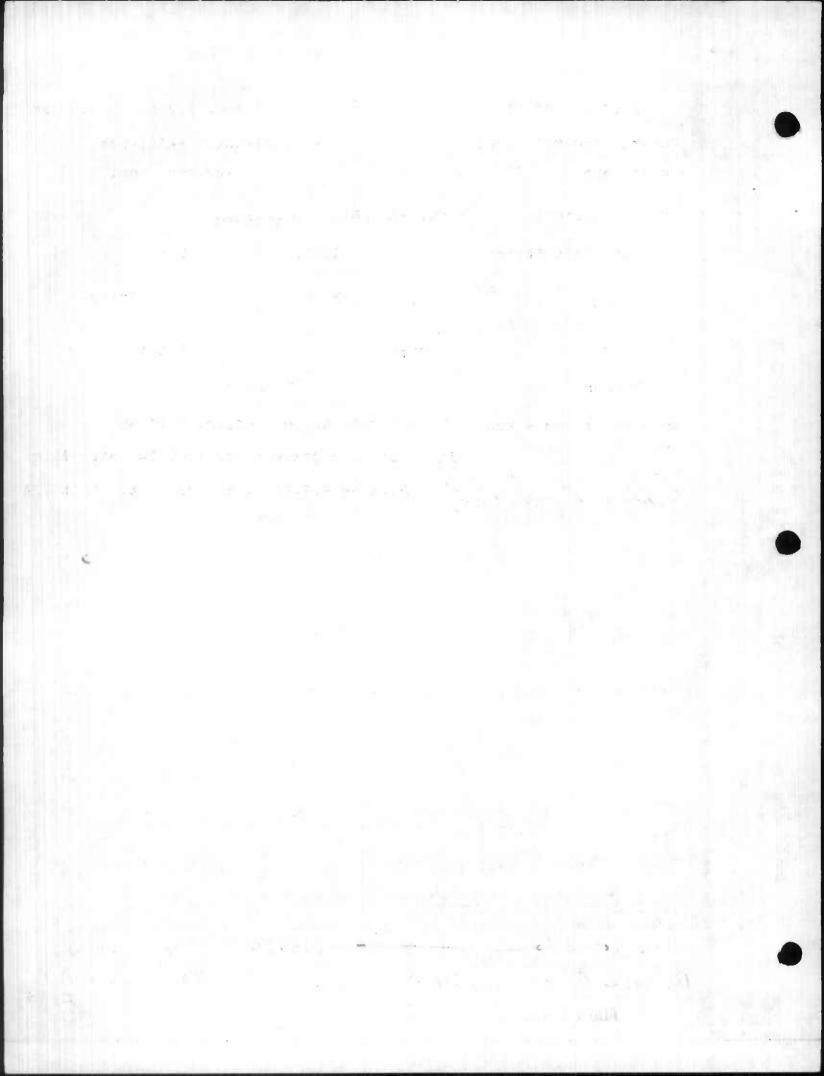
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner as stated.
2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29c. License number 29d. Deta signed (Month, Dey, Year)

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5400 Old CourTRd RANdalISTOWN MD

lichAEL 31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture

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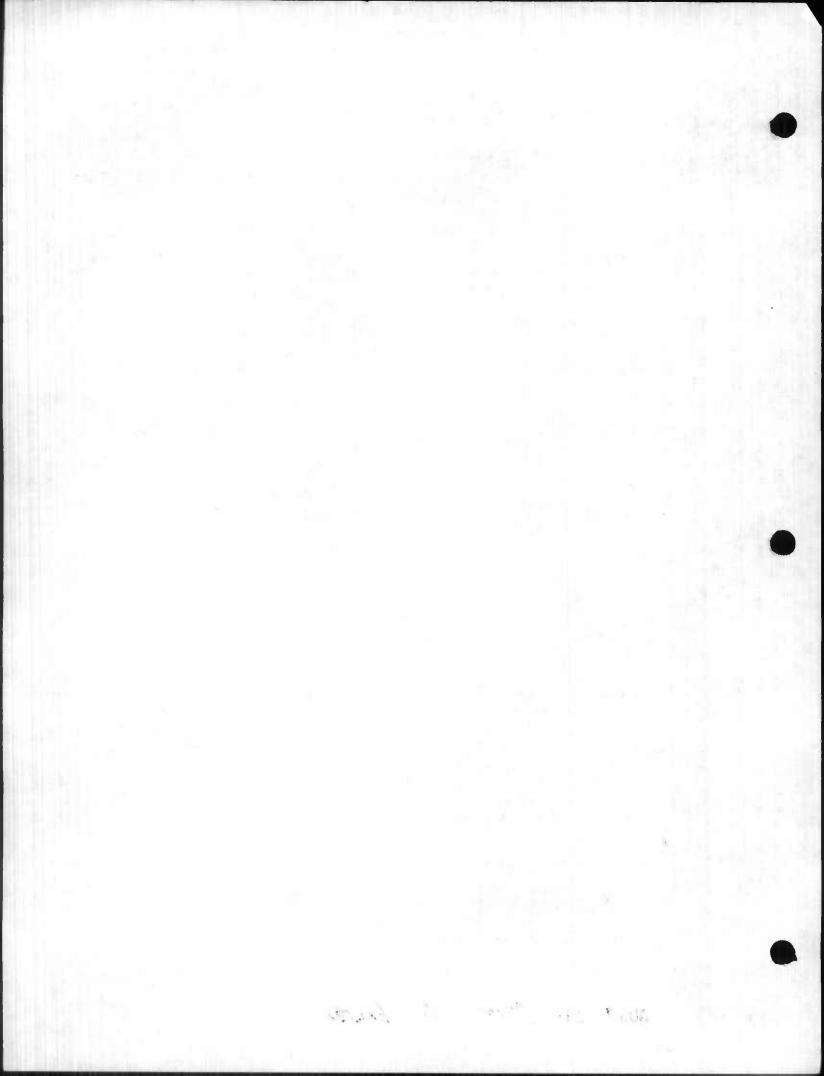
State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G787 9/6/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AUGUST 2000 4:15 PM 4, Dorothy Henning Guercio /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 215-18-6861 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 20 F Months Days Hours Yrs. 218-03-6274
Usual Residence of Decedent Director Sept. 5, 1922 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 238 609 Magnolia Road 21085 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Herra 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: by 3 □Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Payroll Supervisor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h George Stephen Henning Gertrude Elvira Mevius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other tra-phcs. 609 Magnolia Road, Joppa, Maryland 21085

20b. Place of Disposition (Name of cametery, crematory or other place)

Date 20c. Location - City or Town, State Ruth E. Hott-sister Baltimore, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cath. Cem. 8/8/00 Bradshaw, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part. Enter the disease, or complications/het ceused the death. Do not enter the mode of dying, such as carolac or respiratory area.

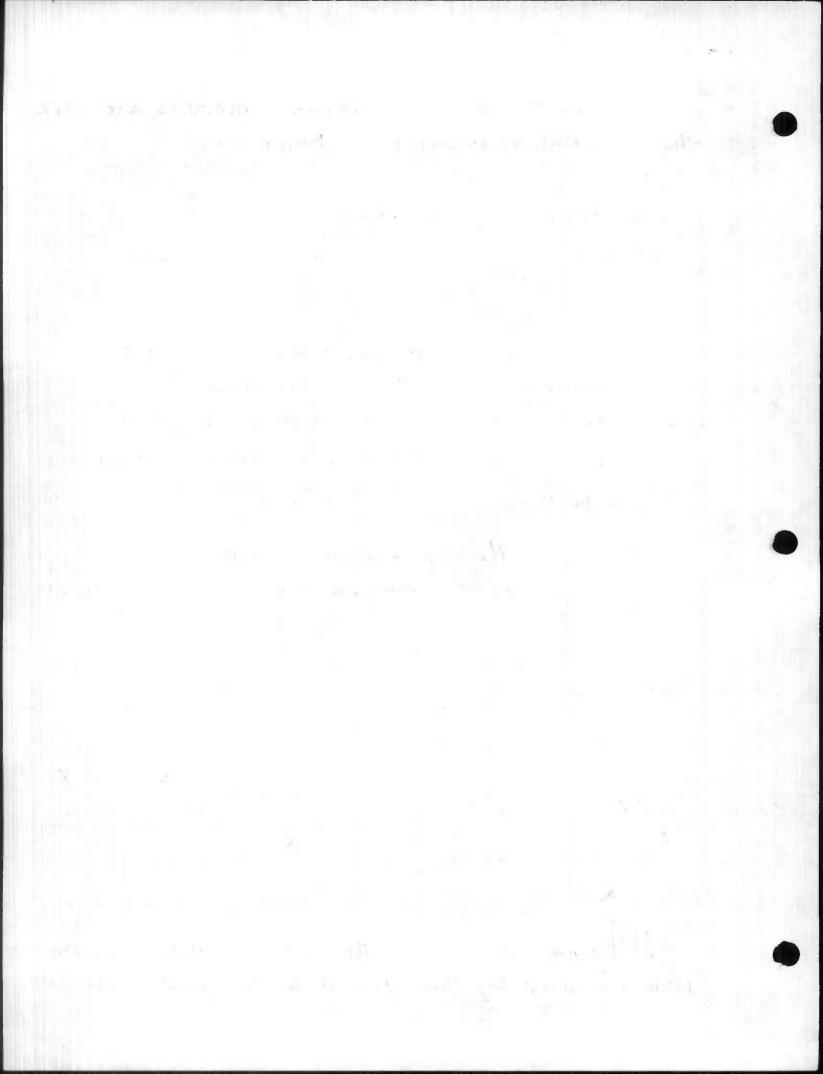
Naryland, 21,009 interval Between the course on each line. Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION /Medical 1 DAY **Examiner** Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of) The law requires that the death certificate be axed 68760. that initiated events resulting in death) Last Due to (or as a consequence of): the 15 Box (USB P.O. | 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not reaulting in the underlying ceuse given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were autopsy tindings available prior to completion of cause of death? page 2 should edical Certification: To Be Completed 24a. Was an autopsy performed? certificata has 1 ☐ Yes 2 No 1 Yes of Vital or Attanding Physician: 25. Was cese referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 1 Whatural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending Investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18-04-2000 D 30263 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 7601 OSLER DRIVE TOWSON, MARYLAND FRANCIS KHOO M.D. 21204 31. Date filed (Month, Day, Year) 32. Registrer's Signature State AUG 7 2000 Registrar

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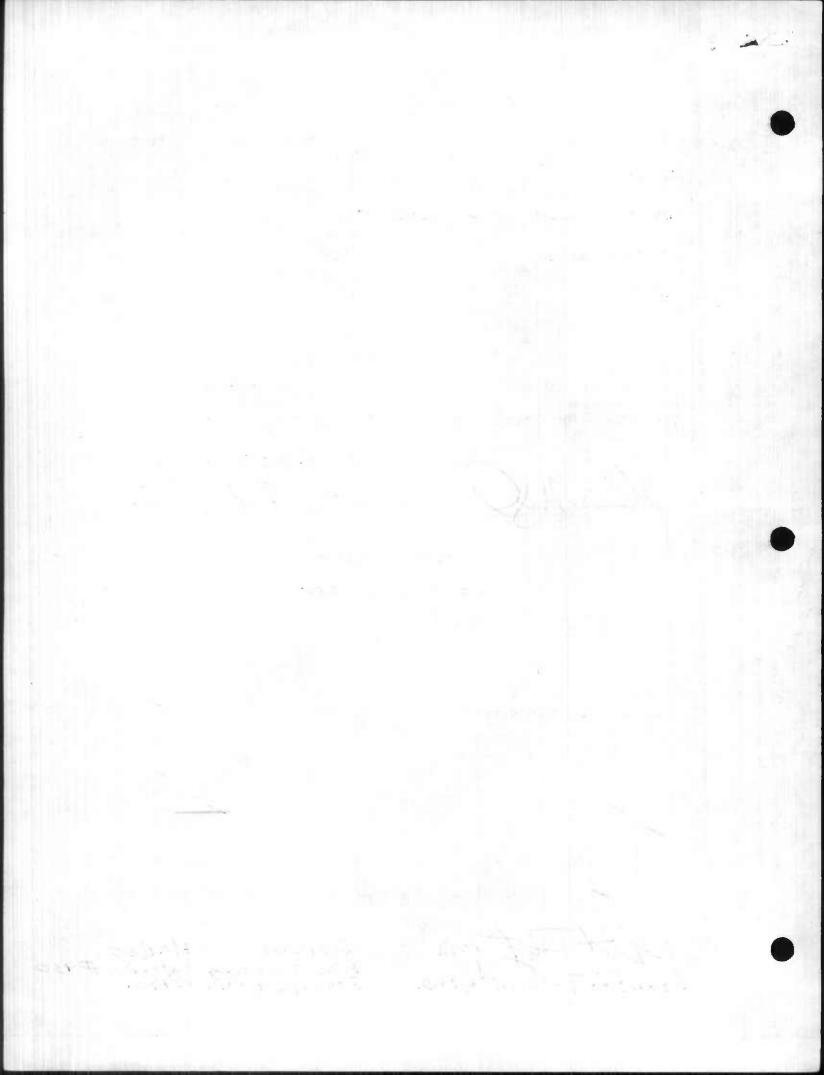
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be notified		10e. Street and Number		10f. Zip Code				10g. Citizen of What C			try?
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el', or teme 23a or 28a-f show Exactine must be notified at the European Discourse	Dy rur	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? 1 X Yes 2 1 Yes, Give Year or Dates:			cedent of I pecify Cub 2 No	Hispanic Orlgin? (Sen, Mexican, Puel Specify:	Specify Yes or Noto Rican, etc.)	lo- 14. Rad Bla Specif	ce - America ck, White, e y: WH	
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2	3	0. Neme and address of person who co	empleted cause of death	n (Item 23a) (Type,		123	000		1-10 (-0 > 1	07	1 200
State	3	Michael Faulkh 1. Date filed (Month, Day, Year) AUG 0 8 20	er Johns 32. Registrar's	HOPKINS Signature	Hos	PITA	L 600	MORTH 1	WOLFE !	T.B	ACT. MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMENDED ITEM#26 PER MD g786 8/24/00 State of Maryland / Department of Health and Mental Hygiene Amended #26, 7/27/2000, per MD, JW, Mont. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** Month Year Walcutt Wilfred Gibson July 20, 2000 2:00pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8015 Maple Ave Takoma Park Montgomery If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Hours Months Days 15 M 2□ F 88 Director 215-25-2305 May 10, 1912 China Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Maryland Prince Georges Temple Hills 1 ¥ Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò 238 4712 Henderson Road 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Barns 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give V Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: WWII Specify: White 3 B Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical Baitimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental I reportant: If Ilem 27 is marked of Orvie John Gibson Mary Moffett 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13575 Nichols Drive Janet Gibson/ Daughter-in-law Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) George Washington Cemetery 07/25/00 Adelphi, MD 22. Name and Address of Facility
Takoma Funeral Home 21. Signature of Funeral Service Lie 254 Carroll St. NW Washington, DC 20012 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or com shock, or heart teilure. List only Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Myocardial Infarction Sudden Examiner Due to (or as a consequence of): Examiner Coronary Artery Disease Many years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Diabetes Many years Box 68760 Physician/Medical Due to (or as a consequence of): 88 P.O. 1 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 | Yee 2 No 3 | Probably 4 | Unknown Dementia, Seizure Disorder be det Records. by 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case reterred to medicat examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Thesidence 6 Clother (Specify) Care Facility 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after deati 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signeture and title of certif 29d. Date signed (Month, Day, Year) D31001 30. Name and address of person who compresed cause of death (Item 23a) (Type, Print) 7500 G-eenway Catri-Stuart J. Turkewitz, M.D. Greenbelt, MD. 20770 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State JUL 2 Registrar

DHMH 16 Rev 6/95



Paula Marie

Physician

Certificate of Death

Dey

6, 200N

2. Date of Death

3. Time of Death

	/Medical Examiner	4e Fecility Name (If not institution, giv	e street end number)	0	4b. City, Town, or Lo		County of Death	2030
	Funeral Director	218-07-0810				8. Dela of Birth (Month, Dey, Year) June 26, 19	9. Birthpla Country	ca (State or Foreign
pmen Harvest	Pages 1 and 2 should be filed within 72 hours after death with the Maryland and of health and 2 should be filed within 72 hours after death with the Maryland and of health and Mertal hygen. The file of the file of the filed within 12 health and 12 healt	Usual Residence of Decedent 10a. Stata 10b. County Marylan 10e. Street and Number 32132 Old Ocean 11. Marital Sletus 1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Et (Specify only highast grave) Elementary/Secondery (0-12) 17. Father's Nema (First, Middla, Last,	12. Was Decedent Ever in U Armed Forces? 1 Yas 2 bl No If Yas Give Yaar or Datas: Sucation Ida completed) College (1-4or 5+) Nabb Type, Print) All Husband 20b. F	13. Was Decedent of If Yas, specify C 1 Yes 2 1 16a. Decedant's Usual Oct (Giva kind of work do life. DO NOT usa ref Refer 1 19b. Meiling Address (Sin Rf 2 Box Place of Disposition (Name of ematary, cramatory or other)	849 If Hispenic Origin? (Spuban, Maxican, Puarto No Specify: Suppation and during most of work (ired) 18. Mothar's Nam Rose aat and Number or Rul 375 Deligolaca)	ecify Yes or No-Rican, atc.) 18b. Kii Ing 18b. Kii A (First, Middle, Maiden Carbox Al Route Number, City on Dete 20c. Lo	zan of What Countred State: 14. Race - Amarican Bleck, White, at Specify: What Specify: Specify: Town, Stata, Zip Country, Stata, Zip Country or Town	d. Inside City Limits 1 XYas 2 No No No No No No No No No No
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	f Vital Record yeldan: The law requin is certificate has been si director, page 2 should	25. Was casa rafarred to medical			26 Place of Deel	1 ☐ Yas 2	v	Yes 2□ No
	Of Vita Physician: This certific ral director.	axaminar? 1 ☐ Yes 2 ☐ No		ER/Outpatient 3 DOA	Other:	oma 5 Rasidence	6 Othar (Specify)	
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	Ne Hospita nn 24 hours Ne Funeral pletely filled	29a. Cartifiar 1 Certifying Ph	ysician: To the best of my knoniner: On the basis of examine and mannar stated.	tion and/or invastigetion, in m	ly opinion, daath occur	red at tha tima, data end	plece, end dua to	tha ceuse(s)
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bone City or Town, Stata, Zip Code) 19940 20c. Location - City or Town, Steta Salisbury Maryland eral 10815 Approximata Intarval Batween Onset and Deeth bacco use contribute to the cause of death? 8 2 No 3 Probably Unknown 24b. Were sutopsy findings evailable prior to complation of cause of death? n autopsy ned? 15 2 No 1 Yes 2 No ence 6 Othar (Specify) w Injury occurred reet and Number or Rural Route Number, n, Stete) ausa(s) and mennar as stated.
ata end piece, end dua to tha ceuse(s) 9d. Data signad (Month, Day, Year) Eastern Shore Dr Salishung MO 2180/

State Registrar ause of death (Item 23a) (Type, Print) 400

32. Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month Yeer Physician OBREY D. HOUCK 8:50 AM AUGUST 4, 2000 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 18 M 2□ F Months Hours Director 207-03-6901 78 19, 1921 PENNSYLVANIA Usual Rasidance of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ¥ Yas 2 No Director 28a-4 MARYLAND N/A BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 8 must be Nerns 23a 4816 EAST HOFFMAN STREET 21205 S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas?

1 Yas 2 No If Yas, Giva 14. Race - Amarican Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Nevar Married 2 Merried natural, or 1 ☐ Yas 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yaer or Datas: 1943-1946 WHITE Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12TH GRADE STEEL WORKER STEEL 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Be 2 should be it and Mental 9 JOHN HARRY HOUCK IDA SIGNORA MELLOTT 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) tant: If hem 27 is Health 4816 EAST HOFFMAN STREET.BALTIMORE, MARYLAND 21205 PAULINE G. HOUCK (WIFE) 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a, Mathod of Disposition Data 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) GARDENS OF FAITH 8/6/00 BALTIMORE, MARYLAND 21. Signeture of Funeral Sarvice Licensee 22. Nama and Addrass of Facility SCHIMUNEK FUNERAL HOME INC. MuleT. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Entar tha disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, ahock, or haart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** /Medical Immediata Causa (Finel 2 DAYS disaasa or condition rasulting in daath) LEFT LOWER LOBE PNEUMONIA Examiner Due to (or es a consequança of) Examiner sician and burial-fransit Sequantielly list conditions, if any, laeding to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical physis the Due to (or as a consequance of): 88 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 3 CORONARY ARTERY DISEASE be det þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy OLD MYOCARDIAL INFARCTION completion of cause of death? 1 Yes 2 No 1 Yes 2 No DIABETES MELLITUS funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospitel: Othar: Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation or Attending 1 XNetural 1 ☐ Yas 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piaca of Injury - At home, farm, street, factory, office building, atc. (Specify) in by 4 Homicide pelli 24 hours a Hospital edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certitier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) antr 151094-1 AUGUST 4, 2000 0 30. Nama and addrass of person who completed causa of daath (Item 23a) (Typa, Print) VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 MELECIA SANTOS, M.D., 31. Data filed (Month, Day, Year) 32/Registrer's Signature State AUG 8 2000

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Registrar

21215-0020

Baltimore, Maryland

Box 68760.

P.O.

Records.

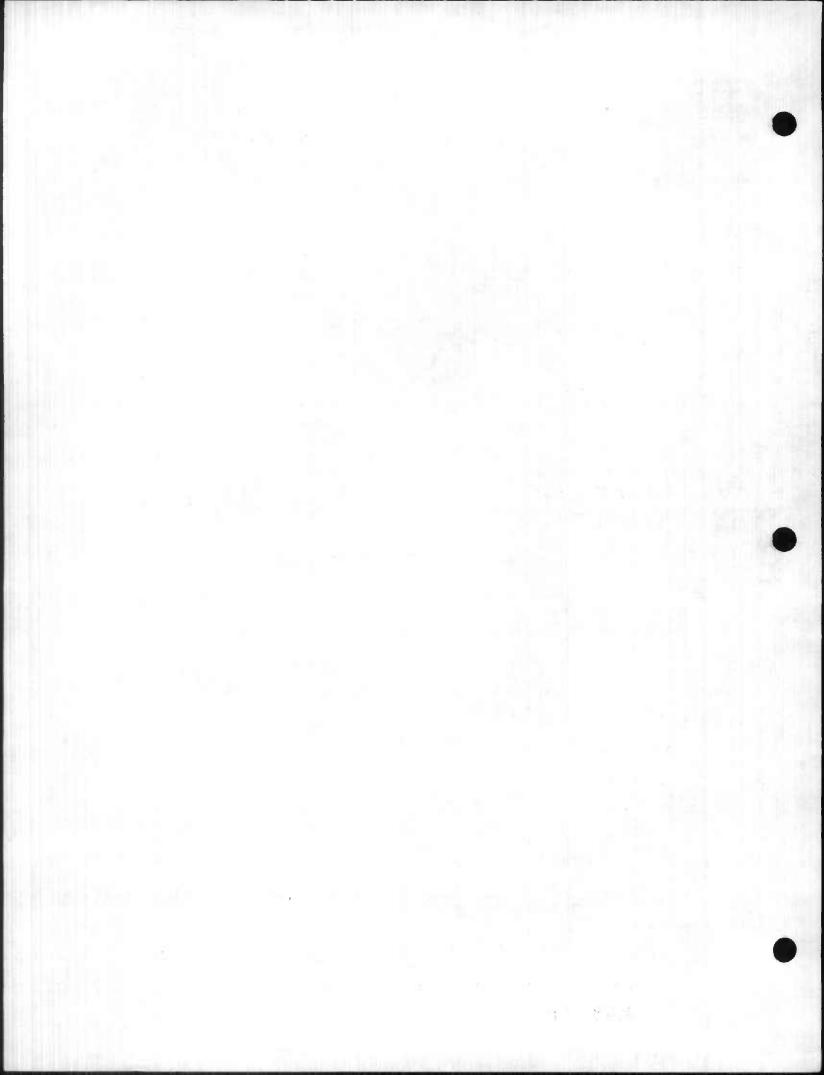
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month James Marion Hooper 3 2000 August 5:45 A.M. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 583 Cressy Road Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 € M 2 □ F Yrs 220-07-5155 83 Mar. 29, 1917 Maryland Usuai Rasidance of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 583 Cressy Road 21014 USA 13. Was Decedant of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U.S. Armed Forcas? 14. Rece - American Indian, Bieck, Whita, atc. 11. Maritai Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Navar Married 20 Merried 1 ☐ Yas 🛠 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilaga (1-4or 5+) 6 President/Owner Refuse Disposal 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Edward Leroy Hooper Emma Viola 19a. Intormant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Eunice L. Hooper - Wife 583 Cressy Road, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cematary, crematory or other piece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta ₽DBurial 2 □ Cremetion 3 □ Ramovai from State 4 ☐ Donation 5 ☐ Othar (Spacify) Harford Memorial Grdns. 8/9/00 Aldino, Maryland 22. Nama and Addrass of Facility McComas Funeral Home, P.A. emas >1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he mail lure. List only one cause on each line. Approximata Interval Between Onset end Death Metastatic Adenocarcingna of Lung Immediata Cause (Final 2month disease or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseesa or Injury that initiated evants rasulting in deeth) Lest Dua to (or es e consequence of): Dua to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case retarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Desidance 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Matural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No

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Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

other traumatic event,

permit. Pages 1 and 2 st Department of Health end Important: If item 27 ie n any injury or other traun

Physician

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Baltimore, Maryland 21215-0020

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Box 68760 Records. P.O. Division of Vital or Attending Fafter death. After To the Hospital of within 24 hours at To the Funeral D completaly

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State Registrar

1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and piace, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end titla of certifier

29c. License number 0 3 3 6 4 2

29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

Kevin (Snydermi)

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

754 Acckory Avente Bel Av MD 21014

31. Data tiled (Month, Day, Year)

2 Accident

3 Sulcide

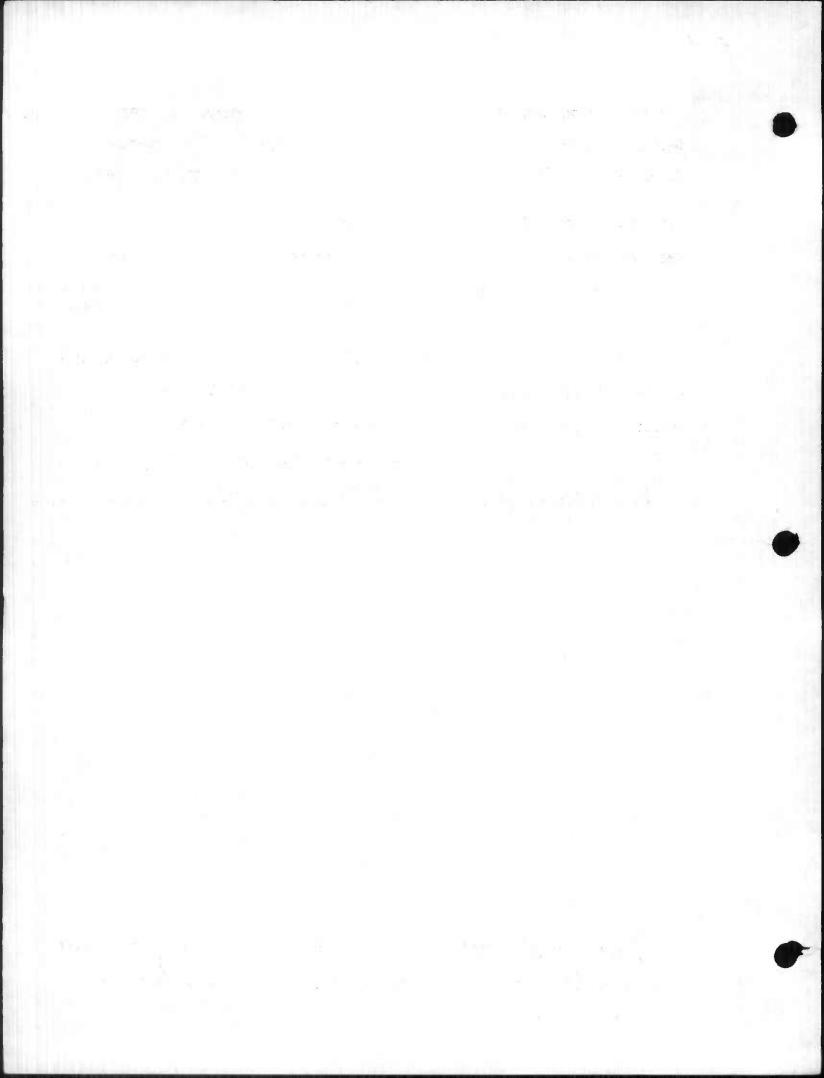
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AUG 7 2000

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32. Registrar's Signatura



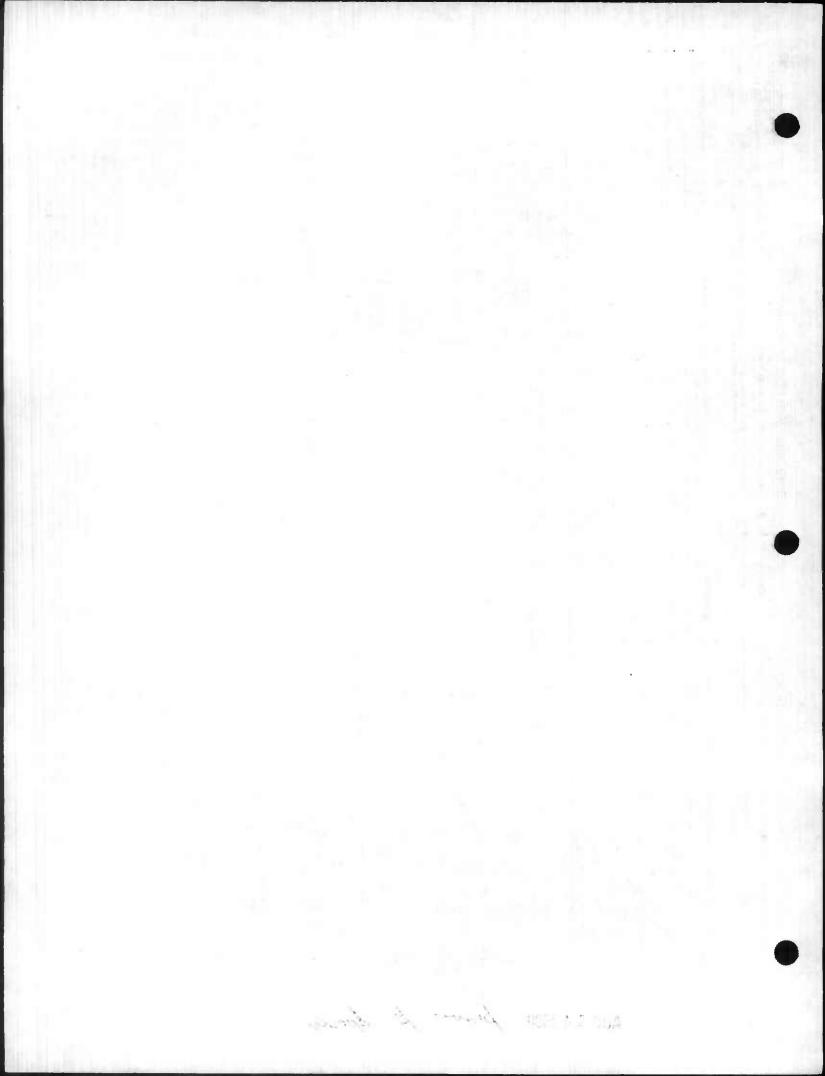
State of Maryland / Department of Health and Mental Hygiene

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17. Father's Name (First, Midd	de, Last)				18. Mother	s Name (First, Mic	Idle, Maiden Surnar	ne)	
Phili	p Crane	Hessi	on			Madeli	ne Rile	У	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 500 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** August 9, William Cody HARPOLD 2000 1:35 p.m. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 114 Sundown Ct., Apt. 1C Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1 M 2 F 98 Yrs. June 8, 1902 Director 212-38-9900 Texas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 114 Sundown Ct., Apt. 1C 21740 USA

"natural", or

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at Herrie 23s Department of Health and Zahould be file important if item 27 is mericany lejury or other

> **Physician** /Medical **Examiner**

The law requires that the death certificate be executed signed by the attending physician I be detached for use as the bunk as the page 2 should ispital or Attending Physician: The hours after death.
Ineral Director: After this certificate y lilled in by the funeral director, pa To the Hospital
within 24 hours a
To the Funeral C
completely lilled

Division of Vital Records, P.O. Box 68760.

Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Merital Stetus Bleck, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give 1 Never Married 28 Married 1 ☐ Yes 2 ☑ No Specify. Specify: white If Yes, Give Yeer or Dates: 1922-25 à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) minister church 12 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) John William Harpold Florence May McPherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drewry E. Harpold - wife 114 Sundown Ct., Apt. 1C, Hagerstown, Md. 21740 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 8-12-00 Frederick, Maryland Resthaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility MINNICH FUNERAL HOME 21. Signeture of Funeral Service Licenses Ucur 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Perf. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 25. Was cese referred to medical axaminer? 1 ☐ Yes 2 No 1 Yes 2 No Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 25€No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Panding investigation Injury 1 Natural 2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier edicai 29b. Signature and IIII 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

AUG 1

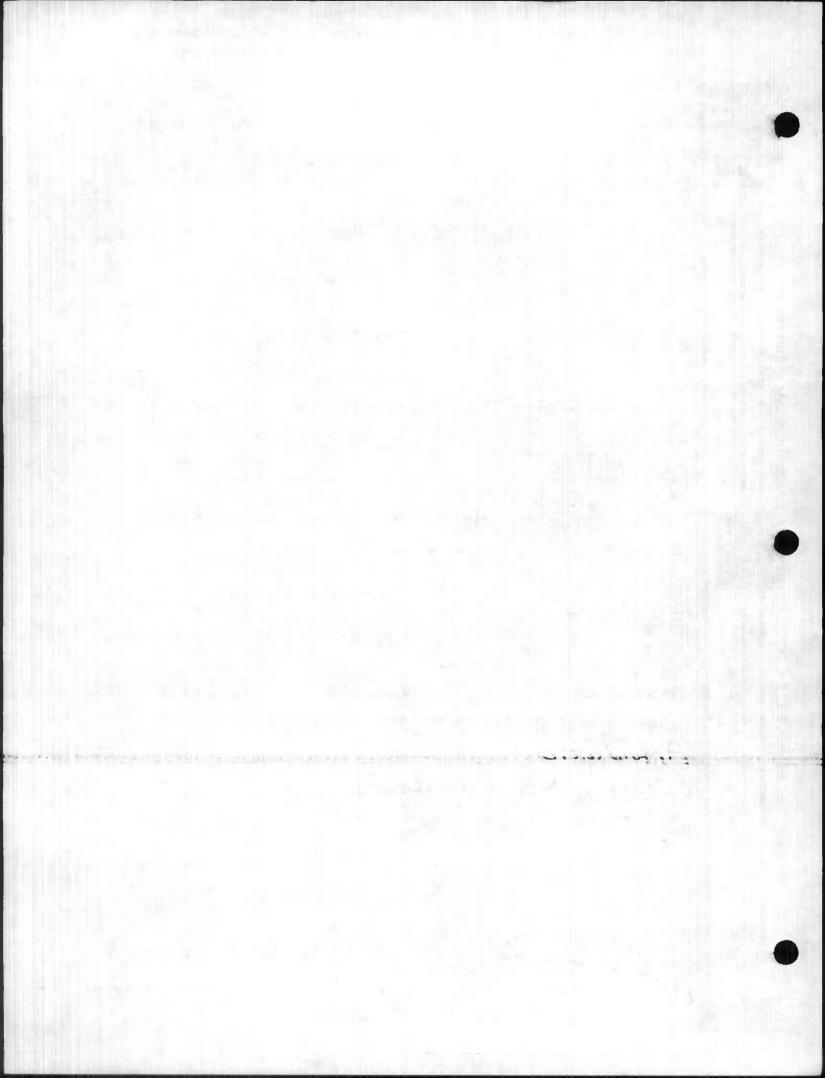
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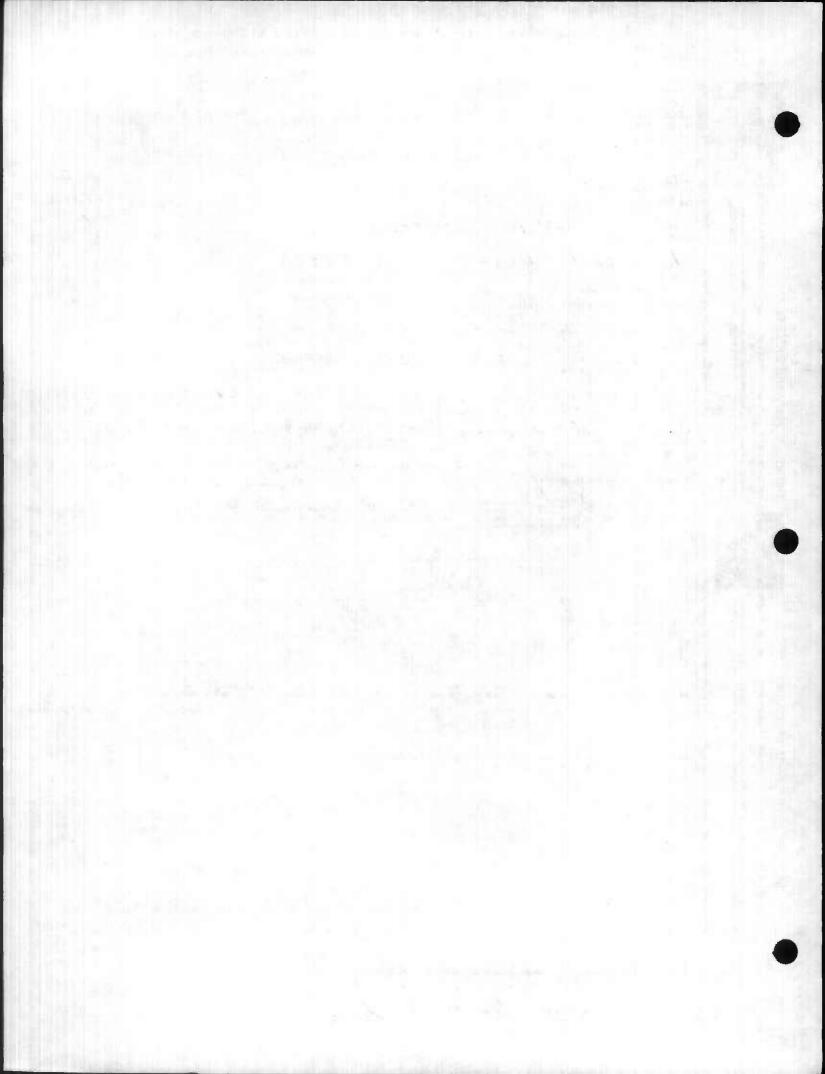
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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Physician			,	ne cause on	each line.			oud or ay	riy, sucii as	Cardiac	or respiratory	ariosi,		-	Interval Between
				ne cause on	each line.			oda or ay	rig, such as	Cardiac	or respiratory	arrosi,			Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 1, Decedent's Nama (First, Middle, Last) 3. Time of Death Dey **Physician** AUGUST 11:50 A.M HAROLD STANLEY KNOWLES 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE BALTIMORE | H Undar 1 Yaar | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Yaar) | June 12, 15 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1⊠M 2□ F Panama 73 508-56-1869 **Director** Usuel Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2000 Director Abingdon Maryland Harford 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? b 105 Wisperwood Court 21009 USA Herrie 23a Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 Yas ∑ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) City Government 4 Social Worker 18. Mother's Nama (First, Middle, Meidan Surname) 17. Father's Name (First, Middle, Last) and Mental I 8 Knowles Leteria (u/k)McClean (u/k)Irving 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Beryl L. Knowles - Wife 105 Wisperwood Ct., Abingdon, MD 21009 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Pages 75 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Bel Air Memorial Grdns. 8/12/00 Bel Air, Maryland 21. Signature of Funaral Sarvice Licansaa 22. Nama and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 23a. Part1. Eplar tha disaasa, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one causa on each line. Approximete Intervet Betw Onset and Death **Physician** /Medical Immediata Causa (Final disaese or condition resulting in death) SEPTIC SHOCK Examiner Dua to (or as a consequence of): Physician/Medical Examiner STAPH AUREAS The lew requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated avants resulting in death) Last Dua to (or as a consequenca of): INFECTED LINE Dua to (or as a consequence of): Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown ORONARY ARTERY DISEASE, STATUS POST CORONARY ARTERY BYPASS of Vital Records, Be Completed by 24a. Was an autopsy performad? 24b. Wara autopay findings available prior to completion of cause of death? GRAFT, HYPERTENSION, END STAGE RENAL DISEASE, HEMODIALYSIS PERIPHERAL VASCULAR DISEASE, MITRAL VALVE REPLACEMENT 1 Yes 200No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Placa of Daeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) Medical Certification: To 1 Yas 250 No 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred Division 5 Pending invastigation 1 SNetural s after death. 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, atreat, factory, offica building, atc. (Specify) 4 Homlcida within 24 hours a To the Funeral C Territying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier MO R192476 AUGUST 8, 2000 30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print)
GEO-PHILIPS CHACKO, HD 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

DHMH 16 Rev 6/95

State Registrar

NOWLES



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey **Physician** MURLAY KLDH2 obcut 11=52 An 2000 /Medical 4c. County of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner SLFALLSTON GENERAL HOSPITAL HAZFORD FALLOTON 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 15€M 2□ F Yrs. Director 63 218-32-6536 16, 1936 Maryland Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes X No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 Funeral USA 713 Tupelo Road 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11 Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) pormit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Nem 27 is marked oth any Injury or other treumetic even 9056. Be William Owings Klohr, Sr. Margaret Virginia Jones 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Margaret L. Klohr/ Wife 713 Tupelo Rd., Edgewood, MD 21040 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 8-5-00 4 ☐ Donetion 5 ☐ Other (Specify) Joppa, Maryland Trinity Lutheran Cemetery McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complication of caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one such as each line. Interval Bety Onset and Death Physician Immediate Cause (Finat disease or condition resulting in death) /Medical SCUD Examiner Due to (or as e consequenca of): Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) use as the Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed раде 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Box 68760, P.O. 1 Records, this certificate of Vital To the Hospital or Attending Physicien: Division efter death. filled in by

Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

10

within 24 hours of To the Funeral C

State Registrar

728 0 32. Registrar's Signeture 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PNASH

31. Dete filed (Month, Day, Year)

BELANUD BELAN MO 21014

2000

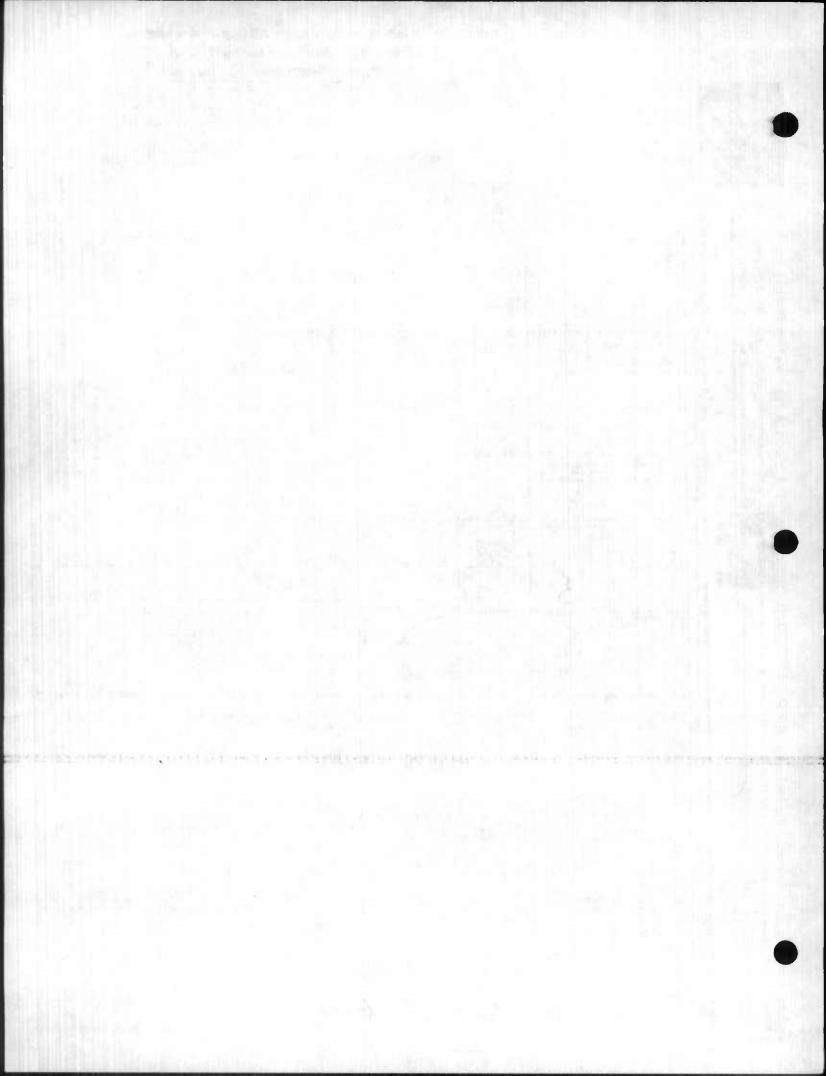
DMG



State of Maryland / Department of Health and Mental Hygiene

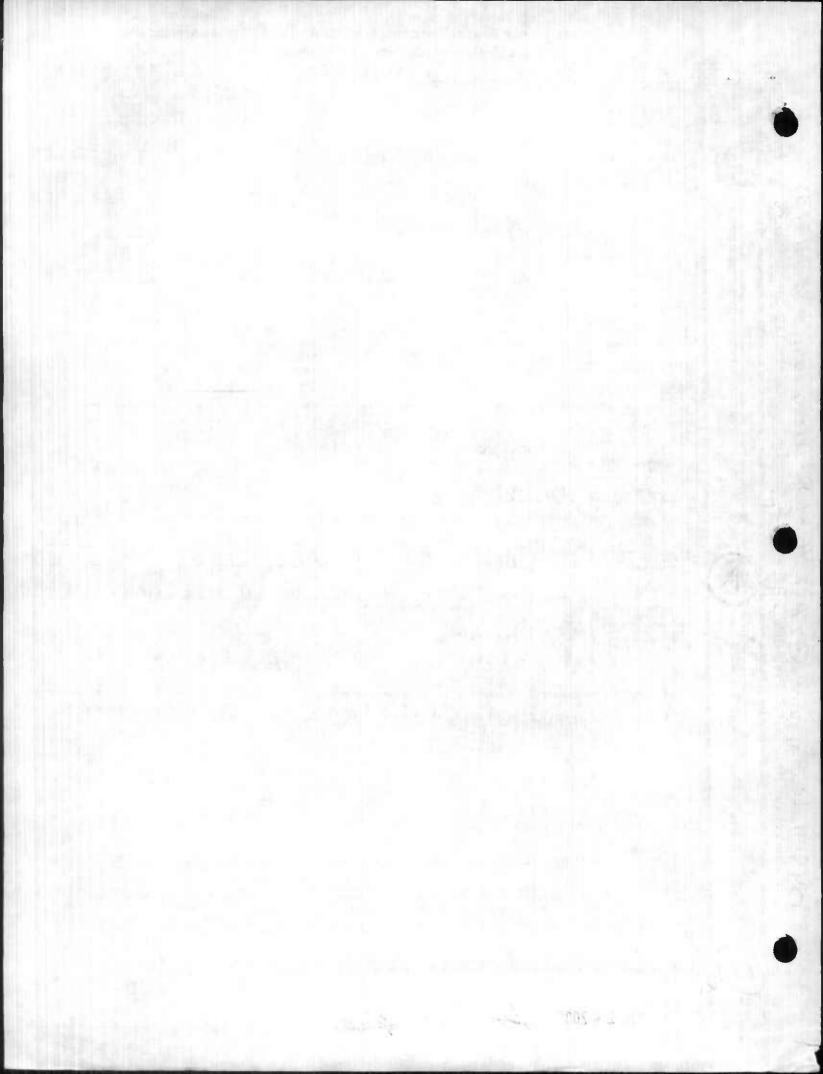
				Cer	tificate	of E	Death		Reg. No.	00	20941
Physician	1. Decedent'a Name (First, Midd							2. Date of D	esth Day	Yaar	3. Time of Death
/Medical	Shirley Kathlee	en KENDALL						August	- 11	2000	5:50
Examiner	4a Facility Name (If not institution	on, give street and number	er)			41	b. City, Town, or L	ocation of Dea	th 4c. Cou	inty of Deatl	n
	48 Wakefield Ro	oad					Hagerst	own	Was	hingt	
Funeral	5. Social Sacurity Number		Aga (In yrs. I		If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ev. Year)	9. Birtl	nplaca (Stete or Fore
Director	216-30-3099 Usual Rasidence of Decedent	1□M 2∏F	65	Yrs.				Aug 8			nnsylvani
M 18	10a. State 10b. County	у	10c. City	, Town or Loc	cation						10d. Inside City Lim
ims 23s or 28s-f show cmust be notified at neral Director	Maryland Wash	ington		Hagers	town						1 ▼ Yes 2 □
284	10e. Street and Number	Ingcon		IIC. ECT 5	10f. Zip C	oda			10g. Citizen	of What Co	untry?
0 0	48 Wakefield Ro	and				217	740		U.S.	Δ	
r tems 23s or 28s-fs niner mast be notified Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U,	S. 13. V	Vas Decedar		spanic Origin? (Si n, Mexican, Puert	pecify Yas or N			rican Indian,
Fur	1 Never Married 2 Mar	Armed Force					n, Mexican, Puerti	Rican, etc.)		Black, White	a, atc.
by	3 □ Widowed 4 □ Divorce	If Yes, Give		1	☐ Yes 2]	No No	Specify:		Spe	city: Wh	ite
*natural; or items 23e or 28e-f show edical Esaminer must be notified at leted by Funeral Director	15. Decede	nt's Education		16a. Deced	ant's Usual	Occupa	ition		16b. Kind o	f Business/l	ndustry
Die Die	(Specify only higher Elamentary/Secondary (0-12)	est grade completed) Collega (1-4c	w 5 . \	(Give I	kind of work OO NOT use	done d retired)	uring most of wor	king			
the tree	12	O O	34)	Wai	tress				Clu	ıb	
In and Mental thygiene. 7 is marked other than "natural traumatic avant, the Medical Traumatic and To Be Completed	17. Fathar's Name (First, Middle	, Last)					18. Mothar's Nan	ne (First, Middle	a, Maidan Sun	rama)	
arked of atic ave	Howard Oyler						Kath1	een Mc	Cleaf		
a mar	19a. Informant's Name/Ralation	ship (Type, Print)		19b. Mailin	g-Addrass (Street a	and Number or Ru	ral Route Numi	ber, City or To	wn, State, 2	(ip Code)
27 le	Julie Vinson -	Daughter		48	Wakefi	ield	Road H	lagersto	own, Ma	rylan	d 21740
Department of health important: If Nem 27 any Injury or other ti once.	20a. Method of Disposition	5555	20b. PI	lace of Dispos	sition /Neme	of		Dete	20c. Location		
ry or o	1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (te	se Hil			1	3/14/00	Hager	etown	, Marylan
Department of Important: If any Injury or once.	21. Signature of Funeral Service		IXO		. Name and						
Departm Importa any Inju	21. Signature of unional solvice	Lace						innich			
	23a. Part . Enter the disease, o shock, or heart failura. Lis	11 -					son Blvc	-		i, Mai	yrand
been signed by the attending physician and should be detached for use as the buriat-transit leted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	6		as a consequence as a consequence			oun C				1 Oyea
d by the attending philetached for use as the Physician/Med	resulting In death) Last Part II. Other significant conditi	d.	but not resu	ilting in the un	nderlying cau	use give	on in Part I.	23b. Dio	I tobacco use	contributa	to the causs of de
d by th								10	Y88 2 N	3 P	robably 4 Unk
page 2								peri	s an autopsy formed?		Wera autopsy tindin available prior to completion of cause of death?
ertifi Se Be	25. Was casa referred to medical examiner?					04-	26. Place of Dea	th (Check only	one)		
al dire	1 Yes 2 No	Hospital:		ER/Outpatient		-	4 ☐ Nursing H	ome 5 Res			city)
5 C	27. Manner of Death 1 ⊠Natural 5 □ Pandi	ing.	Dey Year)	28b. Time of Injury		C. Injury Work		28d. Describe	How injury oc	CUIT90	
· 5 5 0	3 Suicide 6 □ Could	mined 259, PI909 01	Injury - At ho atc. (Specify	me, farm, stre	M eet, factory,		Yes 2□No		(Street and No own, Stete)	umber or Au	ıral Route Number,
one ceam. In Director: At ad in by the fur Sertification	4 Homicida detarr										
4 hours effer death. Funeral Director: Affiled in by the fur- ical Certificatio	29a. Cartifier Certifying (Check only 2 Medical	ng Physician: To the besi	of examinat	viedge, death ion and/or inv	occurred at	the tim	e, data and place pinlon, daath occu	, and dua to the rred at tha time	cause(s) and , date and pla	manner as	steted. to the cause(s)
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To the Funeral Director: All completely filled in by the fur completely filled in by the fur Medical Certificatio	29a. Cartifler) Certifyi (Check only one) Medical	ng Physician: To the best I Examiner: On the basis and manner	of examinatistated.	ion and/or inv	astigation, in	n my op	pinlon, daath occu	and dua to the rred at the time	, date and pla	ce, and dua	to the cause(s)

DHMH 16 Rev 6/95



Am	ended Item#2	7 perPHYG786 8/25/2000	Type or Print EwState of Mar	in Blac yland /	Department of	f Health and	Mental Hy	giene	0 26941
An	mend # .18.1	er FH PGC 7-28-200	JU cr	- 1	Certificate of	or Death		Reg. No.	
	Physician	Decedent's Name (First, Middle, La:	st)	100			2. Date of Dea	ath Dey	3. Time of Death
	/Medical	JAMES E. LEWIS				T	July		2000 2242
	Examiner	4a Facility Neme (If not institution, give				4b. City, Town, or			
		Southern Maryla			W Hadard V	Clinton			ce George's
	Funeral	5. Social Security Number 6. S	ex 7. Age (in yrs. last b	Yrs. If Under 1 Ye		(Month, De	h y, Year)	Birthplace (State or Foreign Country)
6	Director	Usual Residence of Decedent	X	0.3	113.		Novembe	r16,193	6NorthCarolina
m	D & E	10a. State 10b. County	1	Oc. City, Tox	wn or Location				10d. Inside City Limits
-00	Very de so	Maryland Prince G	'oorgo's	Forest	···· 110				1 No 2 No
S	or 28s-f s	10e. Street and Number	reorge s	OLESL	10f. Zip Coo	le		10g. Citizen of V	Vhat Country?
30 Tr		2605 Lorring Dri	370		207	1.7		USA	
4	fler death v fler death v fler munt finer munt	11. Merital Status	12. Was Decedent Eve	er in U,S.		of Hispanic Orlgin? (S Cuban, Mexican, Puer	specify Yes or No		e - American Indian,
J.	her of he	1 Never Married 2 Merried	Armed Forces? 1 X Yes 2 No If Yes, Give				to Rican, etc.)	Blac	k, White, etc.
888	urs a lift, o	3 ☐ Widowed 4 ☐ Divorced		1954-	1 ☐ Yes 2 🔀	No Specify:		Specify	Black
188	72 ho	15. Decedent's Ed	lucation		a. Decedent's Usual Oc	cupation one during most of wo	dina	16b. Kind of Bu	usiness/Industry
		(Specify only highest gra	College (1-4or 5+)		life. DO NOT use re	tired)	King		
Cha	The state of the s	9th		Bu	ilding Ins	pector		Montgom	ery County Govt
. 7. 2	Be Be	17. Father's Name (First, Middle, Last)				18. Mother's Ne	me (First, Middle,	Meiden Sumem	Θ)
3 5	To He	Edward Lewis				Katie	Shippma	n Ship	man
Robins	2 shk and and mm	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Str	reet and Number or Ri	ural Route Numbe	er, City or Town,	Stete, Zip Code)
-	4 2 4 5 5	Marthell Lewis /w	rife		05 Lorring			-	
()	2 2 2 2 X	20a. Method of Disposition 1	Removal from State	20b. Place cemen	of Disposition (Neme of tery, cremetory or other	plece)	Date	20c. Location -	City or Town, State
E	Part in Part	4 Donation 5 Other (Specific		Mary1	and Vetera	ns Cemeter	y7-31	Chelten	ham, Maryland
Ball	Spart Spart Spart	21. Signature of Funeral Service Licer	1888	-	22. Name and Ad	Idress of Facility	RSHALL!	FINERA	L HOME OF MD
50	2 20 2 2 2	Symuly 19	rescue 10	muc	4308 Su	itland Roa			
7	THE LIES	23a. Part1. Enter the diseese, or com- shock, or heart failure. List only	plications that caused the	e death. Do	not enter the mode of	dying, such as cardia	c or respiretory a	rrest,	Approximate Interval Between
1	Physician			1.1					Onset and Death
	/Mertinal Examiner	Immediate Cause (Final disease or condition	(AND	10 1	ESPIR	ATORY	AR	REST	
N		resulting in death)			a consequence of):		4		2
20	1 3 2 3		b. KUP	Tur	ZED A	ORTIC	ANE	4 RYSI	n; z wks
2	19 84 1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Q 5 1	e to (or as a	a consequence of):	00			2 wee
25	2 6 E	Cause (Disease or Injury	c. KCIX	NI		unt			12 113
3)8	odio	that Initiated events resulting in death) Last	^ .		consequence of):	0.1110	1		VI 2 WKS
000	My My		o CERCI	- 13 K	W VASI	MUAR	MC	CIDEN	41 20073
Pos Box	at the death certificate of the attending physician/Medic	Date II Other design			to the condensation as a	a share in Doct I	225 Did	tohanaa uua aa	ntributs to the cause of death?
20	by the lached	Part II. Other significant conditions of	ontributing to death but i	not resulting	in the underlying cause	given in Part I.		Yes 2 No	3 Probably 4 Unknown
30	y Pl	PHEUM	DIYIT	, M	BILLA	1+1 COIX		105 21.110	O Processy
Wis,	The law requires the state has been against page 2 should he Completed by	ACUTE 15	-0 11 1 A	~~~		111101	24a. Wes	an eutopsy	24b. Were autopsy findings available prior to
25	w required should	Modera Log	3 PIRA	101	Cy PA	TLURC	pend	ermed?	completion of cause of death?
Page 1	The law ate has I page 2 s						10	Yes 2 No	1 Yes 2 No
Le	certificate rector, pag	25. Was case referred to medical				26 Place of De	ath (Check only		10.168 20.160
-4 5		examiner?	Hospital:	2 🗆 ER/0	Outpatient 3 DOA	Other:	dome 5 Resi		er (Snecity)
70	Phys oral di	27. Menner of Death	28e. Date of Injury	28b	. Time of 28c.	Injury at Work?		how injury occur	
20 5	Attending F r death. ector: After by the funer iffication:	1 Neturef 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	ear)		1 Yes 2 No			
Sejon Sejon	or Attand after death Director: . In by the	3 ☐ Suicide 6 ☐ Could not b	ZOO. FIELD OF HITTER	At home,	farm, street, factory, off	ice	28f. Location (City or To	Street and Numb	per or Rural Route Number,
76	व निर्मेद	4 Homicide	building, efc.	<i>Specily)</i>			City of 10	wn, olete)	
2	4 2 2 E		yelclan: To the best of r						
0	To the Hospi within 24 hour To the Funer completely fill	(Check only 2 Medical Exam	end menner state	d.	inwor investigation, in r	ny opinion, death occ	ज्ञान्य वर साथ सागर,	vate end place,	and due to the ceuse(s)
	To the within to the common common common within the common commo	29b. Signature and the of certifier	1 1/1	1 0	29c. Lie	cense number		29d. Date signe	d (Month, Day, Year)
	(2)	1 doline	1 - KKA	cup	-MOD	2920	5	7/2	25/2000
	110 km	30/1 ame and address of person who	•		(Type, Print)	00 1		, 11-	
	16	FECIPE C.	ROBINSO	NIN	10. 49	8/ 15 ATTI	eny 4	1, 1501	HESDA, MU
100	State	31. Date filed (Month, Day, Year)	32. Registrar	s Signetura					
1	Registrar	JUL 2 8 2000	perme	1	. Sports			Train!	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26912 Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Physician Howard Berl Leary August 1, 2000 8:00 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 210 Collier Run Road Friendsville Garrett 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 110 M 20 F Months Hours 235-36-6260 Yrs. Director 69 Feb 25, 1931 West Virginia **Usual Residence of Decedent** 10e State 10h County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Frederick Director Frederick notifie 2 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 9506 Bridgewater Court, East 21701 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 Married b 21215-0020 1 ☐ Yes 2 ☑ No Specify: p WW 2 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. filed within Elementary/Secondary (0-12) College (1-4or 5+) 11 th Painter Construction altimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 80 Pages 1 and 2 should be nent of Health and Mental Adam Leary Vanzie Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If of Health a If Rem 27 is or other trax Bonnie R. High, daughter 9506 Bridgewater Ct., East, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State Department of Important: If 4 □ Donation 5 □ Other (Specify) Country Side Crem. Aug 4, 2000 Davidsville, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536 or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, list only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) a Arteriosclerotic Coronary Vascular Disease Examiner Years Due to (or as a consequence of): Examiner attending physician and for use as the burlet-transit The law requires that the dasth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of). Box 68760, Physician/Medical Due to (or es a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 N Unknown م of Vital Records, À Completed 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 2 1 XYes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Division 1 Natural n 24 hours after death.

Per Funeral Director: After pletaly filled in by the fun 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) l Damo H - 26154August 4, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Daniel Miller, D.O., 69 Wolf Acres Drive, Oakland, MD 21550

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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= 4

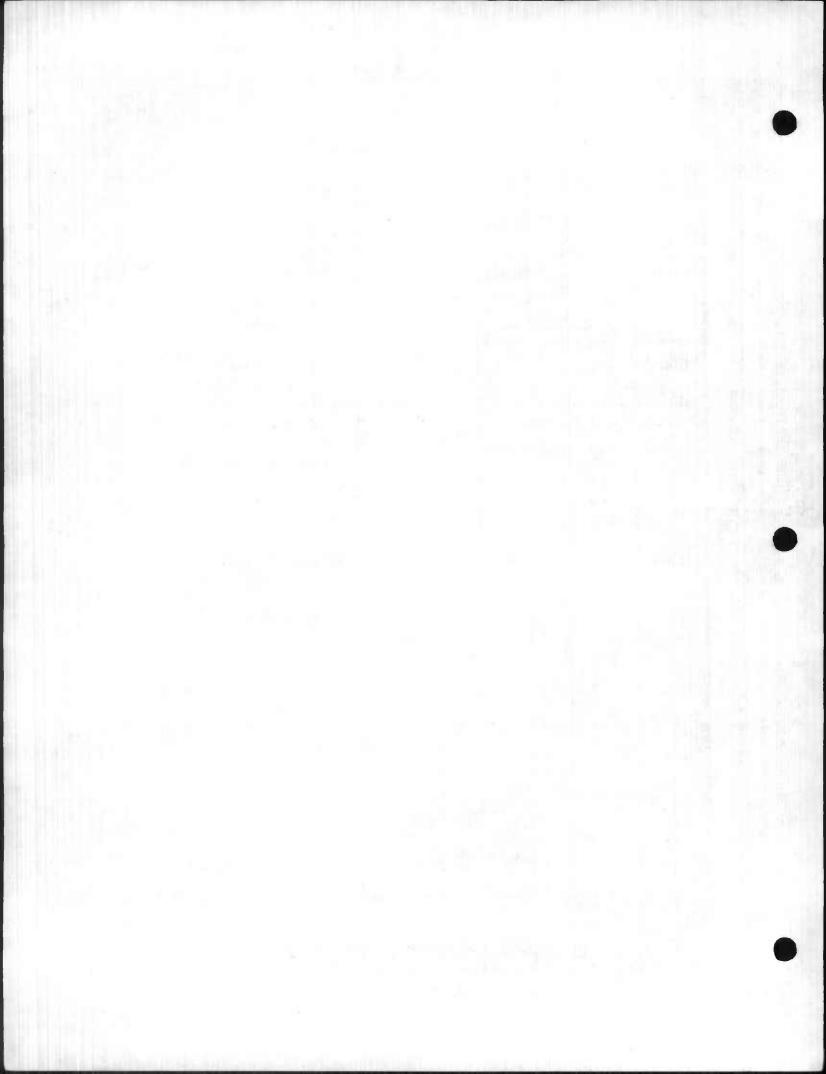
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32. Registrar's Signature

Bayer



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26943 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima ot Death **Physician** MEO MARY 17, 7:50 A.M. AUGUST 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BERLIN NURSING & REHAB CTR. BERLIN WORCESTER If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months 1 M 250F 74 149-14-9048 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits SUSSEX DE. SELBYVILLE 1 ☐ Yes 252No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 222 RIVER RUN 19975 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2000 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ft Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 25 No Specify: 21215-0020 WHITE h 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Hygiene. 9 BOOKKEEPER RETAIL SALES Baltimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hy ant; if flam 27 is marked oth lary or other traumatic event Be FRANK PETTINATO AMELIA LELIO 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Name/Relationship (Type, Print) CATHERINE DILLION/SIS 222 RIVER RUN SELBYVILLE DE. 19975 20b. Place of Disposition (Name of cemetary, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal trom State 4 Donation 5 Other (Specify) FNTOMB N. ARLINGTON, NJ HOLY CROSS CEMETERY 22. Name and Address of Fecility ULLRICH FUNERAL HOME BERLIN, 23a. Pelt1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haen tailure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** tmmediate Cause (Final disease or condition rasulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Box 68760. Physician/Medicai the Due to (or es a consequence of): 88 lor use P.O. Part II. Other significant conditions contributing to death buynot resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 □ Yea 2 □ No 3 Probably 4 ☐ Unknown Division of Vital Records. þ The law requires 24b. Were autopsy tindings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 No or Attending Physician: 25. Was casa ratarred to medical axaminer?
1 ☐ Yas 2 ☒ No Be 26. Place of Death (Check only ona) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Atter 5 Pending Investigation 1 Natural 1 Yes 2 No death. hours after death 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

On the physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical Within 2 To the complete 2 29d. Date signed (Morgh, Day, Year) 29b. Signature and title of certific D004822 DR addition to her completed cause of death (Item 23e) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

Registrar

AUG 1 7 2000

TEO, MARY

with sitting

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Deta of Daath Month MARSHALL L. 8 9 2000 5:30am 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Daath Pocomoke City Hartley Hall Nursing Home Worcester If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yea 3/6/1916 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 10 M 20 F 84 Yrs. Maryland 214-28-7987 Usuai Rasidenca of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2□ No Worcester Pocomoke City 10e. Street end Numbar 10f. Zip Coda 10g. Citizen of What Country? 1006 Market Street 21851 USA 12. Wes Decadant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Year or Datas: Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxicen, Puarto Rican, etc.) Race - Amarican Indien, Biack, Whita, atc. 11. Meritai Status 1 Naver Married 2 Married 1 ☐ Yas 2 XNo Specify: white 3 Widowed 4 □ Divorced 15. Decadant's Educetion (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Coliaga (1-4or 5+)

Retail Sales

20b. Piaca of Disposition (Nama of cematary, cramatory or other place)

m01129

Name and autrass of person who complated causa of death (Item 23a) (Typa, Print)

23a. Part1. Entar tha disaasa, or complications that caused the deeth. Do not anter tha moda of dying, such as cerdiac or raspiretory errast, shock, or haart failura. List only ona causa on each lina.

Photography

20c. Location - City or Town, Stata

8-9-2000

Approximete Intarval Batween Onset end Death

18. Mothar's Nama (First, Middle, Maiden Surnama)

Bertha Olive Myers

103 Linden Ave., Pocomoke City, MD 21851

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

Remson United Methodist Cemetery 8/12/00 | Stockton, Maryland

22. Name and Addrass of Facility Holloway Melson Funeral Home, P.A.

188 Parkview Ave., Golden, CO 80401

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

10a. Stata

17. Fathar's Name (First, Middla, Last)

20a. Mathod of Disposition

Henry Washington Lambertson

Priscilla Marshall (daughter)

1 Buriai 2 ☐ Cramation 3 ☐ Removal from Stata

19a. Informant's Name/Ralationship (Type, Print)

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signature of Funar Sarvice Licensee

Funeral

Director

ten 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Macinal Exposurer mast be notified at

permit. Pages 1 end 2 should be filed within 72 hours eft. Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic avantations.

Examiner

Physician/Medical

ettending physician end for use es the buriel-transit Hospital or Attending Physician: The law requires that the death certificete be executed 24 hours after death. Funeral Director: After this certificate hes been signed by the estending physician end P.O. Box 68760, 2 Records, þ Completed Division of Vital Be Certification: To To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by the

Immediata Causa (Final disaasa or condition rasulting in daath)	Diabelie	Kenal	2 Dise	ase	2915
Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last	Dua to (or as a consequence of	ent Leabi	tes Mellite	s 6 grs
Pert II. Other algnificant conditions con	tributing to death but not re-	sulting in tha underlying	causa givan in Part I.	23b. Did tobacco use co	ontribute to the cause of death
anemia Colon	. Care	noma	of aterus	24e. Was en autopsy performed?	24b. Wara autopsy findings availebla prior to complation of causa of death?
25. Was cesa refarrad to medicei			26. Placa of De	eath (Check only ona)	
axaminar? / 1 ☐ Yes 2 X No	ospital:	ER/Outpatiant 3 0	OA Othar: 4 Nursing	Homa 5 ☐ Rasidance 6 ☐ Ott	har (Specify)
27. Mannar of Death 1. Matural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 Yas 2 No	28d. Dascribe how Injury occur	
3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarminad	28a. Piace of Injury - At h building, atc. (Speci	oma, farm, straat, facto	ry, office	28f. Location (Streat and Number City or Town, Stata)	ber or Rural Routa Number,
29a. Cartifiar 12 Cartifying Phye (Check only one) 2 Madical Examin	Iclan: To the best of my known: On the basis of axamine and mannar stated.	owiadga, daath occurradation and/or invastigatio	d at tha tima, date end place n, in my opinion, daath occ	ce, and dua to tha causa(s) and m curred at tha tima, data and place,	annar as stated. and dua to tha causa(s)
29b. Signature and title of certifier	7	(2)	c. License number	29d. Date signe	ed (Month, Day, Year)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

State Registrar

Medical

(3 6 4 8

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** 12:25 AM MARIAN ROWAN MANIFOLD Aug. 10,2000 /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hart Heritage Estate Street Harford If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6 Sex Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 200 Months Devs 205-16-5299 95 Director 4/6/1905 Pennsylvania Usuel Residence of Decedent the Maryland 10c City Town or Location 10d Inside City Limits r 28a-f show 10a State 10b Counts 1 Yes X No PA York Director Delta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or With 514 Broad St. Ext. 17314 USA death Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ XXX If Yes, Give Year or Detes: "naturel", or items 14. Race - American Indien. 11 Meritei Stetus Bleck, White, etc. Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental hygiene.
Int. If Item 27 Is marked other than "natural", or item
INY or other traumatic svent, Its Modice Examinariny or other traumatic svent, Its Modice Examinariny. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 X Specify: Specify: White by Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumeme) 17 Fether's Neme (First Middle Last) Be Nelson G. Rowan Wheeler Nancy 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Relationship (Type, Print) 514 Broad St. Ext , Delta , PA 17314

20b. Place of Disposition (Neme of cametery, cremetory or other place)

Dete 20c. Location - City or Town, Stete NAncy Watson- daughter 20a. Method of Disposition 1 Kurial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If eny Injury or 8/14/00 Airville, PA 4 ☐ Donetlon 5 ☐ Other (Specify) Chanceford Cemetery 22. Name end Address of Fecility 21. Signature of Funerel Service Licensee Harkins F.H.Inc.,600 Main St., Delta, PA The disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and failured. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** PARKINSONS DISEASE /Medical Immediate Ceuse (Final years disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) attending pl for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the causs of death? been signed by the s should be detached 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed is certificate has director, paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was cese referred to medicel 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 27. Manner of Deeth 28b. Time of After 1 Netural 5 Pending Investigation death. 1 Yes 2 No after death.

Director: A
d in by the fo 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homiclde To the Hospital or within 24 hours aft To the Funeral Di completely filled in Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end manner as stated.

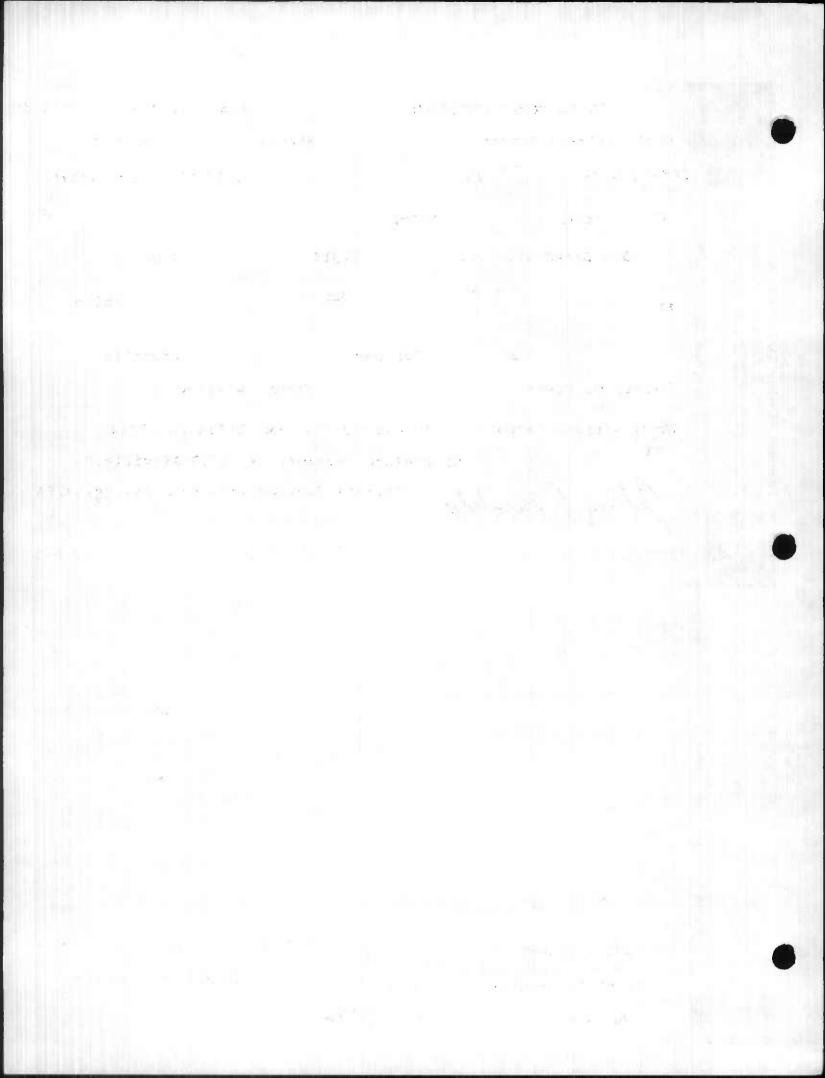
2 Msdical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29e, Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier 10 August 2000 615 west MACPHAIL BULAIR MA 21014 30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Dr. Alfred Sparks 31. Date filed (Month, Day, Yeer) 32/Registrer's Signature State

Jen

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DHMH 16 Rav 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vest **Physician** August 1:10 Am Mattie Emma McCullough 2000 07 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harre de Grace Harrford itizen's Nursing Home If Under 1 Year Months Days H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Director 219-10-4599 95 05/20/1905 Virginia Usual Residence of Decedent 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f ahow traumstic event, the Medical Example, must be notified at the Maryla 1X Yes 2□No Directo Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 610 North Adams St. USA 21078 Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 10 No
If Yes, Give
Year or Dates: 14. Race - American Indian. 11 Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mentel thygiene. Important: If item 27 Is marked other than "natural", or her 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 year Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther T. Elder Mary Casper Rodenhizer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Janet Cohen- Daughter 4130 Webster Rd., Havre de Grace, MD 21078 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 8/9/00 Havre de Grace, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace,

23a. Paul Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,
shock, or heart failure. List only one cause on each line. Iny MD 21078 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Dell. Examiner Examiner physicien and the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings avaitable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed After this certificate has 219MS 1 ☐Yes 2☐No funeral director, 25. Was case referred to examiner? Be 26. Place of Beath (Check only one) Other: 4 Auraing Home 5 Pesidence 6 Other (Specify) 2 1 Yes 2 No 1 [Inpatient 2□ER/Outpatient 3□ DOA 28d. Describe how injury occurred 27. Manner of-Oeath 28b. Time of Certification: 28s. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ENutural 5 Pending 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 8 To the Hospital within 24 hours a To the Funeral D 29a. Certifier edicai 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Morgh, Day, Year) 29c. License number e of death (Item 23a) (Type Pres ess of pa

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31. Date filed (Month, Day, Year)

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Mc Cullough, Mattie

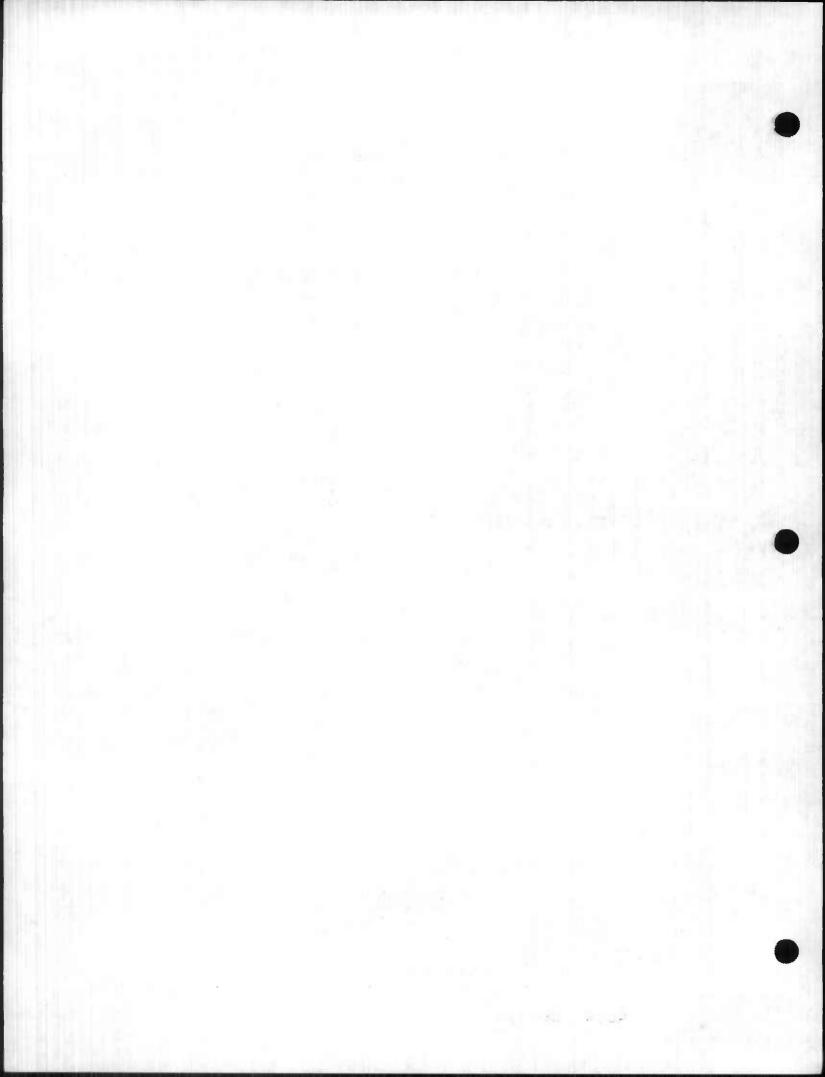
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 00 26918

				Certificate of	f Death	Re	eg. No.	20040
		1. Decedent's Name (First, Middle, Las	st)			2. Date of Death		3. Time of Death
	Physician	Hope (nmn)	Miller			August	1, 2000 Year	10:45 AM
	/Medical Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo		4c. County of De	
	LAAIIIIICI	Harford Memor	ial Hospital		Havre de	Grace	Harfo	had
-	Funeral	5. Social Security Number 6. S		ast birthday) If Under 1 Yes	ar If Under 24 Hrs.	8 Date of Birth	9 B	irthplace (Stata or Foreign Country)
н	Director	216-28-7276	□M 200 80	Yrs. Months Day	s Hours Min.	(Month, Day, Dec. 2,		Virginia
Ь	*1	Usual Residence of Decedent	, 00			DCC . 2,	1919	VIIGIIII
	ylan M M	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Mer Iled	Maryland Harfo	rd	Aberdeen				1X Yes 2 No
	or 15s-fs be notified Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What C	Country?
		103 Edmund Stree	+	210	01		USA	
	ther death iner must siner must Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Decedent of	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Arr	
0	atter mine mine	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		ıban, Mexican, Puerto	Hican, etc.)	Black, Wh	ite, etc.
02	D 50 0	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 💆 N	o Specify:		Specify:	hite
9	od within 72 ho ygiene. we than "natur it, the Medical.	15. Decedent's Ed		16a. Decedent's Usual Occ	upation	1	16b. Kind of Busines	s/industry
27	ple ple	(Specify only highest gra	College (1-4or 5+)	life. DO NOT use reti	e during most of workingd)	ng		
2	the the	8	Oonege (1 401 01)	Homemaker			Own Hom	e
P	d other Hy	17. Father's Neme (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Maiden Sumeme)	
lar	Menta Menta stice To B	Bethel	(uk)	Blevins	Nonnie	(nmn)	Anderson	
Maryland 21215-0020	Short Man	19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Stre				, Zip Code)
	27 11 2	Robert Miller /	Son	2317 Edwards	Lane, Bel	Air. MD	21015	
re,	1 Hall	20a. Method of Disposition	04	ace of Disposition (Name of			20c. Location - City of	or Town, State
Baltimore,	ant of the state o	Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State			3 00	D-1 34	M77
=	arte ortan	21. Signatule of Funeral Service Licen	DET	Air Memorial	Gardens 8	-4-00	Bel Air,	Maryland
Ba	Page 1000	Maria O Go	0010/-		Funeral Ho			
		23a Phyl Enter the disease or com-	plications that coursed the death	Do not enter the mode of d	kesbury Ro	ad, Abin	igdon, Mar	yland 21009
		23a. Part1. Enter the disease, or compshock, or heart taiture. List only	one cause on each line.	. Do not ones the mode of a	ying, daon as condict	n roopiratory arre	551,	Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	C L	, (٧ -	1 +		
	Examiner	disease or condition resulting in deeth)	· Leve Dr	Lascular	Accid	len		1 week
	ē		Due to (or	as a consequence of):				
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_	be executed ician and bunial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or	as a consequence of):				
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B	The law requires that the death ce sale has been signed by the attendings age 2 should be detached for us. Completed by Physician/					1 001 0111		
0	the dy the ched	Part II. Other significant conditions of	ontributing to death but not resu	illing in the underlying cause :	gren in Part I.			ite to the cause of death?
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Records,	v requires that been signed I should be det		1/ (/)			24a. Was a	n autonsy 24t	b. Ware autopsy findings available prior to
Ö	been s should	Coronary	Lytery	Disease		perform	med?	completion of cause
3ec	has the post of th	0 /0	17	0				_ot death?
	Con Con	Severe K.	ena Ins	utticiency		1 🗆 Ye	es 21460	1 Yes 2 10
of Vital	Physician: The lavithis certificate has ral director, page 2. To Be Comp	25. Wes cesa referred to medical axaminer?	Hospital:		26. Place of Deat	n (Check only on	ie)	
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	Affer the funeral funeral tion:	27. Manner of Death 1 Netural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of linjury 28c. In	Vork?	280. Describe no	ow injury occurred	
Sic	Attending in death. sctor: After by the fune fill cation	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	204 1		Pound Plants About as
Division	tal or Attending P rs after death. al Director: After ti led in by the funera Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, offic	ee .	City or Town		Rural Route Number,
	Oltal Ce							
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funer completely filled in by the funer Medical Certification:	(Check only 2 Medical Exam	ysician: To the best of my know hiner: On the basis of examination					
	Within 2 To the complet	29b. Signature and title of certifie	and manner stated.	200 Lion	nse number	20	9d. Date signed (Mo	onth Day Year)
	P N N	250. Signature and title of certifia	^	250. Lice	1	-	A. A. A	
	^	111	M	V	19153	7	rugusi	1,000
	(0)	30. Name and address of person who	completed ceuse of death (Item	23a) (Type, Print)	8 Lau	1 StVs	ret.	1
	W.	MANUEL	M- WAD	NMD	Aben	dear	Marya	nd 2100)
	State	31. Date filed (Month, Dey, Year)	62. Registrar's Signet	A L		/	/	
	Registrar	2000						

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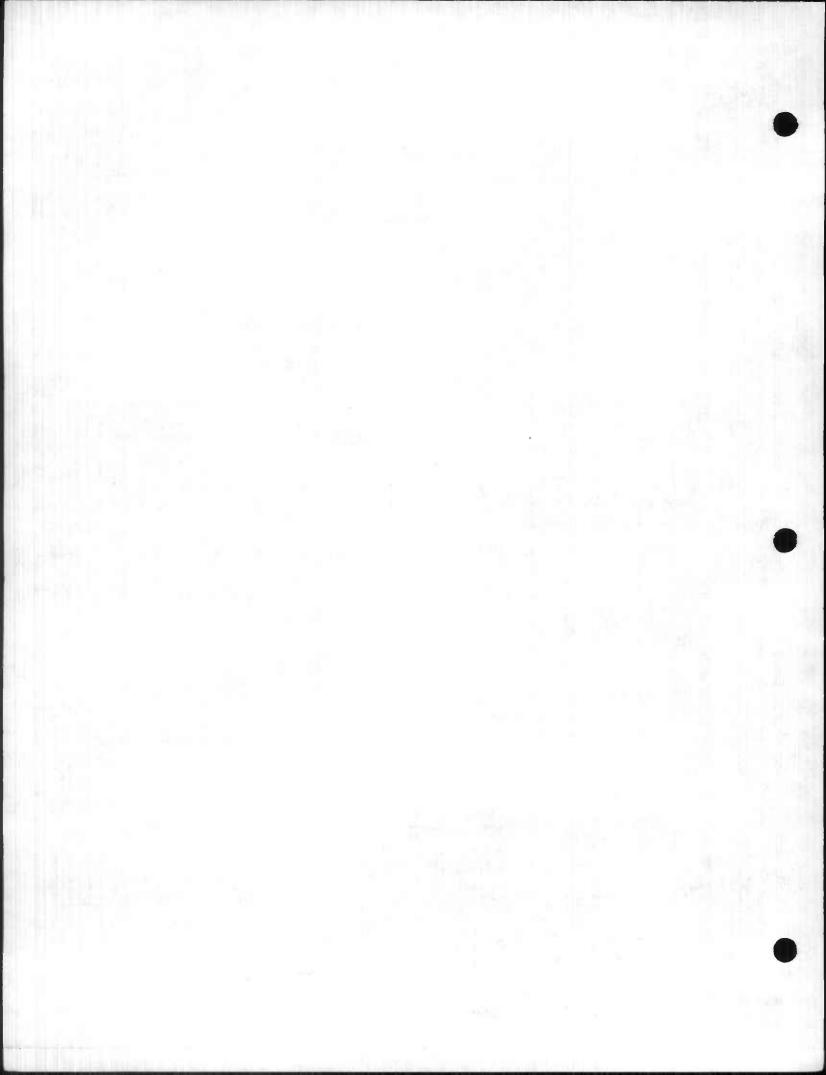
AVET MAN por to force

State of Maryland / Department of Health and Mental Hygiene

26949 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** VERONICA 5:30 Pm MARTIN Aua 1. 00 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington 8. Data of Birth (Month, Day, Year) Feb. 8, 19 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (tn yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 20 F Days Hours 90 Months 215-26-2003 1910 Director Maryland Usual Residence of Deceden 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Washington Director Maryland Hagerstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 S. Walnut Street Apt. 107 B 21740 USA death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detas: 14. Rece - American Indian, Black, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritat Stetus 72 hours efter 1 ☐ Never Merried 2 ☐ Merried Specify: White Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) se filed within 7 lai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) clerk retail grocery other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked othe any injury or other traumatic event, pbbs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fsther's Name (First, Middle, Last) Samuel Edward Basore Lucy Elizabeth Moore 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, Stata, Zip Coda) Nephew 13415 Keener Rd. Hagerstown, Maryland 21742 Donald R. Mowen 20a. Method of Disposition 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, Steta I ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 8/10/00 Hagerstown, Maryland Rest Haven Cemetery Mure of Funeral Service Licensee 22. Name and Address of Fecility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on aech lina. Approximete Intarvat Between Onset and Deeth **Physician** tmmediata Causa (Final disease or condition resulting in deeth) /Medical ATHEROSCLEROTIL CANDIDVASCULAR DISTEASE month Examiner Examiner DEMENTIA 14cen. physician and the burial-transit certificate be axecuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) 280 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown NONE Division of Vital Records. by 24b. Wera eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? certificate has 1 Yas 2 No 1 Yes 2 No Be 25. Wes case refarred to medical examiner? 26. Place of Death (Check only ona) 1 Yes 2 No Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 10 this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred to Hospital or Attending Pin 24 hours after death.

The Funeral Director: After to bletchy filled in by the funeral Certification: 28c. Injury at Work? After Natural 2 Accident 5 Pending investigation NA 1 Yes 2 No NAM 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide NIA 1 Sertifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the I within 2 29c. License number 29b. Signeture and title of certifier 29d. Dete signed (Month, Day, Year) 8.6.00 D28365 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue MANZAR. J. SHAP1. Hagerstown, MD 21742 31. Date filed (Month, Day, Year) 32. Registrer's Signature State AUG 1 0 2000 oak Registrar

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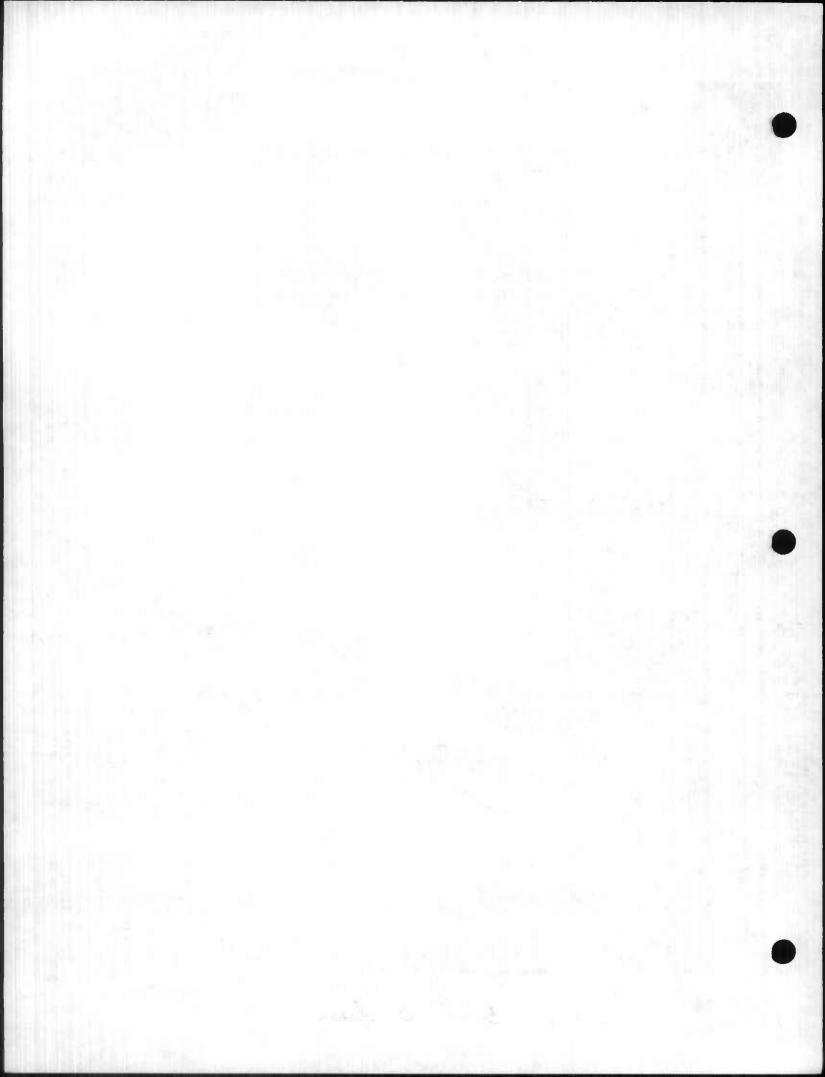
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	1. Decedent's Name (First, Middle, Last)								2. Date of Death 3. Time of Death						
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/Medi Exami		Ab City Tourn or I								ation of Death	4c. County	of Death	1		
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o affar		1 Never Married 2F Married	1 Yes	1 ☐ Yes 2 ☐ No If Yes, Give			1 ☐ Yes 2 ☑ No Specify:			110411, 010.7					
DOO2	d by	3 ☐ Widowed 4 ☐ Divorced	21					^{Specify} White							
172 h	ete	15. Decedent's Education 15. (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo							t of workin	16b. Kind of Business/Industry					
21215-0020 d within 72 hours after giene. rr than "natural", or the	Completed	Elamantary/Secondary (0-12)	Elamantary/Secondary (0-12) College (1-4or 5+)										Manufacturing		
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2 5575		Lorraine V. Mo	atz (W	life)	1435	7 Penn	Ma	r Hia	h Ro	ck Rd.	Cascad	de. Mo	d. 21719		
or Hear I from		20a. Method of Disposition	Demousl from	20b. F	Place of Disp cemetary, cra	osition (Neme matory or other	of er piec	:e)		Date	20c. Location	- City or To	wn, State		
Limo Page ment of lury or		Rest Haven Cemetery 8/16/2000 Hagerstown, Md.													
Baltimore, pemir. Pages 1 ar Department of Hea Important: if Hem 2 any injury or other		21. Signature of Funeral Servica Licensee M. 0849 Paul T. IO Sauto													
m 89728		Paul T. To Same Lochstampfor Funeral Home, Inc. 48 S. Church St., Waynesboro, Pa. 17268 23a. Part 1. Enter the disease, or complications that a led the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between Onset and Death													
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DIVISION To the Hospital or Attendin within 24 hours after desith. To the Funeral Director: At completely filled in by the fu	Σ	29b. Signature and title of cartifier	20	10	est (29c. l	Licenso	e number	121	50	29d. Date sign	ed (Month,	Day, Year)		
		Kallerill	renze	svoc tu	7564	an	L	100	12	77	Ava	11	2,000		
		30. Name and address of person who	completed caus	se of death (Iter	h 23a) (Type	Print)	1.	0	6/0	001-0	X.V	N	1/1010		
	ote	31. Date filed (Month, Day, Year)	1 1 T	Segistrar's Signa	TOIUP ature	vice !		C.	(10	4012	(own	clk	- H142		
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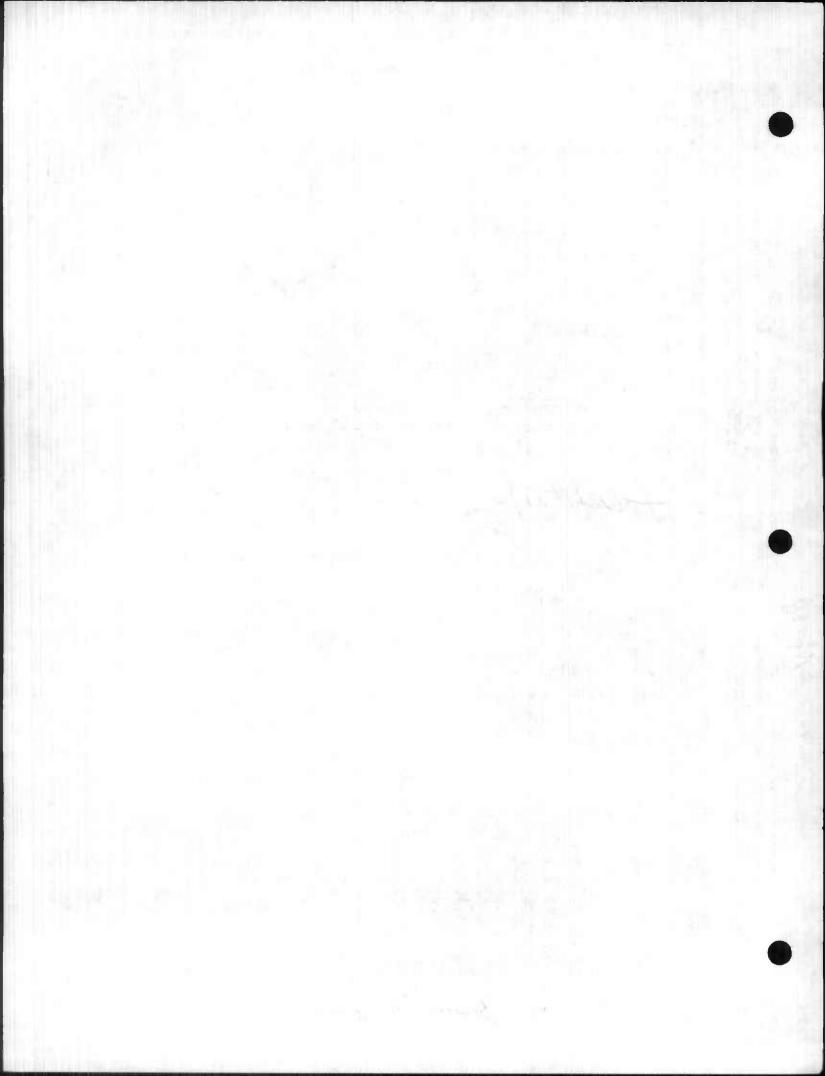
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State of Maryland / Department of Health and Mental Hygiene 00 269

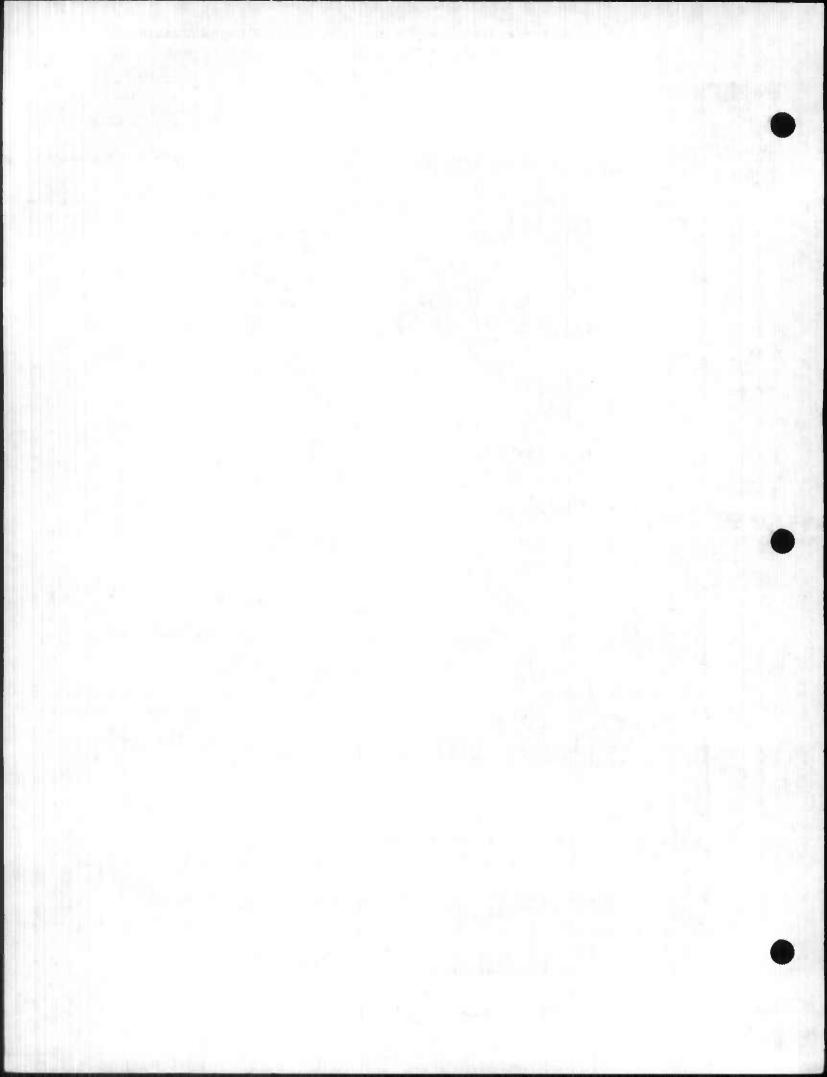
						Ce	ertifica	te of i	Death		Reg. No.	-		
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Man	10	MD	Washingt	on	На	gerst	own				1 √2 Yas 2 □ N			i
the Maryler	be notitied Director	10e. Street and Nun				0		o Coda			10n Citizen	of What Cour	ntry?	-
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Maryland 21215-0020 to 2 should be filed within 72 hours aff this and Markel Pygleshes.	ene.	19s. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda)									Coda)			
ore, Maryland 212: ss 1 and 2 should be filed within of theelth and Mentel Hygiene. Item 27 is marked other than other traumatic event, the the		Linda May	Wolfens	berger	/ niece	446	Mitc	hell	Ave. H	agersto	wn, MD	21740		
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8	Examiner			b. Mil	12979)	18						i		
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70	unial E	Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause Disagraph of the Cause Di												
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To the Hospital of within 24 hours all of the European	completely filled in Medical Cert	one)	2 Medical Exal	and man	nar stated.	illon and/or i	nvastigatio	i, in my o	pinion, gaatn occ	orrect at the time	s, data and pia	ce, and due t	o (ng cause(s)	
thing the	M M	29b. Signature add	title of certifier	1 1			29	c. Licans	a number		29d. Data si	gnad (Month,	Day, Year)	mo-4
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State of Maryland / Department of Health and Mental Hygiene 0 0 26952

			(Certificate	of Death		Reg. No.	a) Cas	0 3 3 %	
1 5 71	1, Decedent's Name (First, Middle, Li	ist)				2. Date of D	eath Day	Year	3. Time of Death	
Physician /Medical	Lester Lero	4 Myers		JR		Aug		2000	9;45 A	
Examiner	4e Facility Neme (If not institution, gi	re street and number			4b. City, Town,	or Location of Dea	th 4c. County	of Death		
	Washington Count	y Hospital			Hage	rstown	Wa	shing	ton	
Funeral		Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F 7.0		Months		Hrs. 8. Date of Bi Min. (Month, D	rth ay, Year)	9. Birthp	lace (State or Foreign try)	
Director	213-12-7733	18 M 2UF 78	Yı	\$.		Jan.	7, 1922		ryland	
P .	Usual Residence of Decedent 10a. State 10b. County	10c C	ity Town	or Location				1	0d. Inside City Limits	
the Marylar retor								- "	1 Yes 2 No	
the Minorities	Maryland Washir	gton	Н	lagersto						
death with the Maryland ms 23s or 28s-f show finant be notified at	10e. Street and Number			10f. Zip (10g. Citizen of			
23a	13122 Resh Road			1	21740		USA			
ifer death with the Ma r flems 23s or 28s-fs ifer must be notified Funeral Director	11. Meritel Status	12. Wes Decedent Ever in U Armed Forces?	J,S.	13. Was Decede	ent of Hispanic Origin' fy Cuben, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	o- 14. Red Bla	ce - America ck, White, e		
0 0 0	1 Never Married 2 Married	1 ∑Yes 2 No	100	1□ Yes 2	☑ No Specify:		Specif	y: whi	+0	
natural, o	3 Widowed 4 Divorced	Year or Dates: WW						WIII		
ed within 72 ho ygiene. er then "naturn ft, tre Medical Completed	15. Decedent's E (Specify only highest gr		1	Give kind of worl	dent's Usual Occupation kind of work done during most of work		16b. Kind of B	usiness/Ind	siness/Industry	
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should by the Menta Ment	Lester Leroy My					ie M. Mos				
od 2 in the r trac	19a. Informant's Name/Relationship			-	(Street and Number o				Code)	
	Doris G. Myers -				sh Rd., Ha					
20 2 2	20a. Method of Disposition 1₺ Burial 2 ☐ Cremation 3 [cemetery,	Disposition (Nam crematory or oti	e or her place)	Date	20c. Location	- City or To	wn, State	
permit. Page Department of Important: If any Injury or ansa.	4 Donation 5 Other (Speci	(y) R	ose I	Hill Cem	netery	8-16-00	Hagerst	own,	Maryland	
	21. Signature of Funeral-Service Lice	1600 AA TA	0	22. Name and	Address of Facility	MINNICH	FUNERAI	HOME		
	15,200	VI Mine	0	415 E.	Wilson B	lvd., Hag	erstown,	Md.	21740	
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	plicetions that caused the dee	ith. Do no						Approximate Interval Between	
Physician	shock, or heart failure. List only	one cause on each line.							Onset and Death	
/Medical	Immediate Cause (Final	1								
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executed in and in-trensit	Convention the ties constitues	b		nsequence of):	EC MOON O	party				
EX8	if any, leading to immediate		tale	A A	0 11000					
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-trensit completed by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	X	nsequence of):	Gustan &					
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r requires that the death cer been signed by the attendir should be detached for use leted by Physician/A						24a Wa	s en autopay	24b. W	ere autopsy tindings	
The law require sate has been signated and page 2 should Completed	myserten	5100					formed?	ev:	milable prior to	
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frer tunere	27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tir		Bc. Injury at Work?		how injury occu	rred		
or Attending after death. Director: After In by the fune ertification	2 Accident investigation			М	1 ☐ Yes 2 ☐ No					
rect in by	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	nome, fam ify)	n, street, lactory,	office		(Street and Num own, State)	ber or Rura	l Route Number,	
To the Heapfal or Attending Physician: The law within 24 burs after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp										
L hours	29a. Certifier Certifying Pi	nyaician: To the best of my knominer: On the basis of examina	owledge, o	death occurred a	it the time, date and p	lace, and due to the	e ceuse(s) and m	anner as st	ated.	
To the Hospital within 24 hours To the Funeral completely filled	one)	end manner steled.	ation and	or introdugation,	ar my opinion, dodin		, dato and place	4110 000 10	1110 00000(0)	
To To To	29b. Signature and title of certifier 29c. License number 25								Day, Year)	
	170	MD			(34 PIII8)	5	Aug 1	4. 0	1000	
	30. Name and address of person who	completed cause of death (Ite	m 23a) (T	ype, Print)						
	YANPING YU	12931		c Hill	Ave. He	revstow	n. J	MD	21)42	
State	31 Date filed (Month Day Year)	32. Registrer's Sign		4 1	11		-			
Registrar	AUG 1 5 2	JUU Denera	/	O pp	ocks	J				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Dey Month **Physician** HARDING MACALLISTER 2 2000 13:08 PM JANE AUG. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO 1514 RIVERSIDE DR. APT B 306 SALISBURY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) B. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2\ F JUNE 15, 1913 Director 209-10-5548 87 OHIO Usual Residence of Deceden 10a State 10b County r 28a-f show 10c. City. Town or Location 10d. Inside City Limits to Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b munt be Name 23s APT. 306B 21801 U.S.A. 1514 RIVERSIDE DR. Funeral al Hygiena. I other than "natural", or thams want, the Medical Examiner in 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FASHION DESIGNER TEXTILE 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be nerit of Health and Mental ELBERT R MOSES, SR. HELEN M. MILLER 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a of Other frau LANCE J. MACALLISTER 307 WHITMAN AVE SALISBURY, MD 21801 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) 8/4/00 CAMBRIDGE CREMATORY CAMBRIDGE, MARYLAND 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility 705 E. MAIN ST. SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC. Ly 23a. Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Fine) disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner **burial-transit** that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760, Physician/Medical Due to (or as a consequence of): 100 USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No Records, þ 5 8 Completed 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to should completion of cause of death? page 2 1 Yes 2 0 1 ☐ Yes 2 ☐ No certificate Division of Vital Attanding Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4□ Nursing Home Residence 6 □Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after deal Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. Medical 29a. Certifier (Check only To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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address of pegant who completed cause of death (Item 23a) (Type, Print)

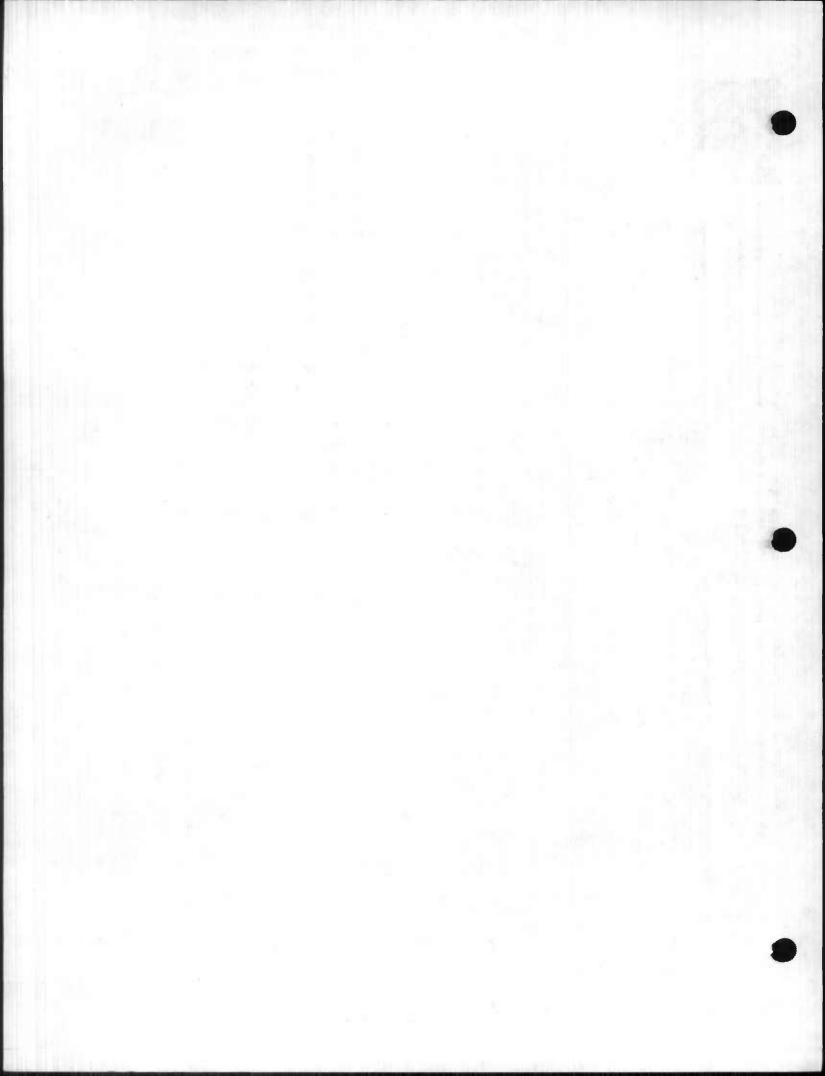
32. Registrar's Signature

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31. Date filed (Month, Day, Year)

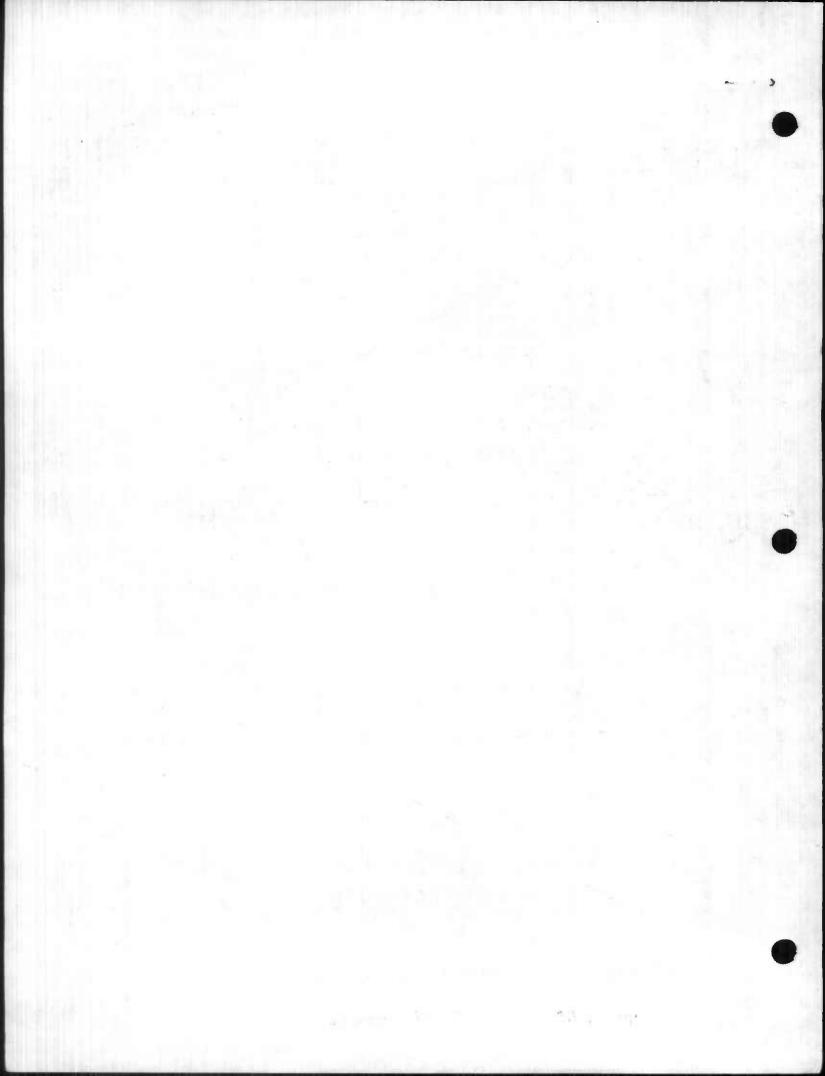


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** APRIL 21,2000 1540 SARAH V. MATTHEWS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nama (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S COUNTY HOSPITAL CHEVERLY 5. Social Security Number 578 – 38 – 9240 If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) 9. Birthplaca (Stata or Foreign **Funeral** 1 M 2 XX Months Days Hours Min 1925ATHENS, Yrs. **GEORGIA** Director Usual Rasidence of Decedant 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28s-1 show XXYas 2 No MARYLAND PRINCE GEORGES SEAT PLEASANT Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? hems 23a 6010 BALTIC STREET 20743 UNITED STATES Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas X2/DXNo If Yas, Giva Year or Datas; Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 72 hours after 1 Never Married 2 X Married Specify.AFRO-AMERICAN ò Baltimore, Maryland 21215-0020 1 Yas XXXNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Hygiene. Elemantary Secondary (0-12) 2 YEARS DOMESTIC PRIVATE 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) merhad o ahould be LEROY PLUMMER SUSIE M. WYNN A BLA 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If them 27 is in any Injury or other traum once. 3512 EVEREST DR., TEMPLE HILLS, MD MILDRED M. BUTLER/DAUGHTER 20b. Place of Disposition (Nama of cemetery, crematory or othar placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata XX Xurial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) FOREST HILLS CEMETERY 4-26-2000 CLINTON, MARYLAND 5 □ Othar (Specify) 22. Nama and Addrass of Facility DUDLEY FUNERAL HOME DUDLEY MT. RAINIER, MD 20712 LDWARD M. 5200 RHODE ISLAND AVE Enter the disaasa, or complications that caused the death. Do not linter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Intarval Batw Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 68760 Dua to (or as a consequence of): 8 Box Part II. Other a ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0 1 Yes 2 No 3 Probably 4 Unknown Š þ of Vital Records, 24b. Wera sutopsy findings svailable prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 1 No 1 Yas 25. Was case referred to medical 26. Placa of Death (Check only one) 2 ER/Outpatient 3 DOA Hospital: 1 ☐ Inpatlant Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 100 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Attac Division or Attending 5 Pending investigation Natural 1 Yas 2 No 2 Accident after death 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and mannar stated. 29a. Certifier 29d. Date signed (Month) Day, 29b. Signature and titla of certifier 29c. Licensa number 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) KAREN MCGIBBON 5100 AUTH WAY, SUITLAND, MARYLAND 20745 32 Registrar's Signatura 31. Date filed (Month, Day, Year) AUG 1 5 2008 Registrar

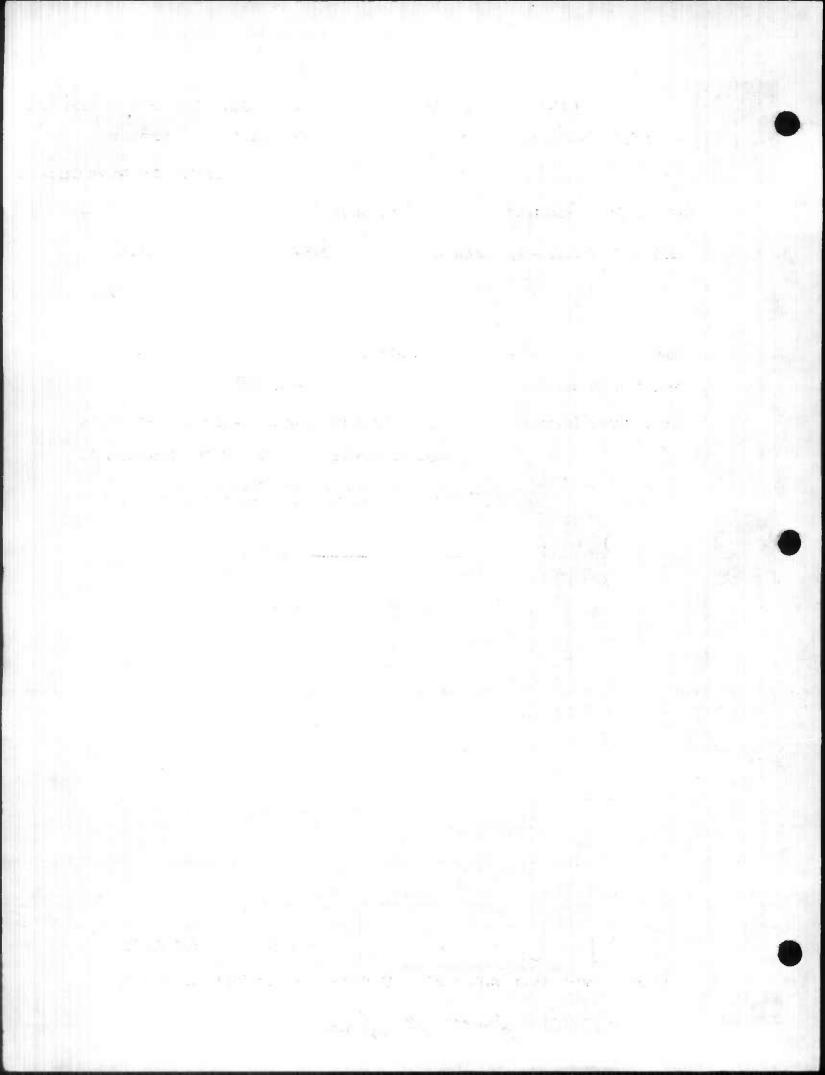
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Physic /Medi		1. Decedent's Name (First, Middle, La	est)			2. Dete of De	_		3. Time of Death			
Examine		BUTI	LER NA	NCE		June	27, Day 200	OO ear	8:34 A.M.			
		4a. Facility Neme (If not Institution, git Alice Byrd Tawes		2	4b. City, Town, or L Crisfi			of Deeth Prset				
Funeral Director			Sex 7. Age (In g 125M 2□ F 95	yrs. last birthday) If Un Yrs. Mont	der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Dete of Bird (Month, Da February	th Year) 1905	Count	ace (State or Foreign ny) th Carolin			
a-f show	tor	10a. State 10b. County South Carolina Ric	chland 10c	. City, Town or Location CO1	umbia			10	od. fnside City Limits 13€ Yes 2 □ No			
23a or 28	Funeral Director	10e. Street and Number 1302 Heidt Stree	t - Apartment		Zip Code 29204		10g. Citizen of W	Vhat Count	ry?			
netural, or items 23a or 28a-f show	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		cedent of Hispenic Origin? (Specify Cuben, Mexican, Puertos 212 No Specify:	pecify Yes or No Rican, etc.)		e - Americe k, White, e Blac	itc.			
than the	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	•	king	16b. Kind of Business/Industry					
of Health and Mental H Itam 27 is marked out	To Be C	17. Father's Neme (First, Middle, Last Butler W. Nance,	Sr.	,	18. Mother's Nam Sara F	ord						
		19a. Informant's Name/Relationship (Vivian Baker (Nic			ess (Street and Number or Ru lt St Apt.				Code) 204			
		20a. Method of Disposition				Date	20c. Location -					
			Tromoval nom State		netery 7	/1/2000	Colum	mbia,	SC			
Department Department If any injury or once.		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Randolph Cemetery 21. Signature of Edneral Service Licensee Robert H. Bradshaw, Jr. 20b. Place of Disposition (Name of cemetery) 21. Signature of Edneral Service Licensee 22. Name end Address of Fecility Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817										
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nding pl	Ical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initioted events resulting in death) Last	C	o (or as a consequence o								
nding pl	Ical	thet initieted events	c	o (or as a consequence o	v():	23b. Dfd t	obecco usa con	atribute to	the cause of death?			
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hes been signed by the attending pl	by Physician/Medical	resulting In death) Last	dontributing to death but not	o (or as a consequence of	v():	1 🗆 1	an autopsy	24b. Werever	The autopsy findings lieble prior to pletion of ceuse eath?			
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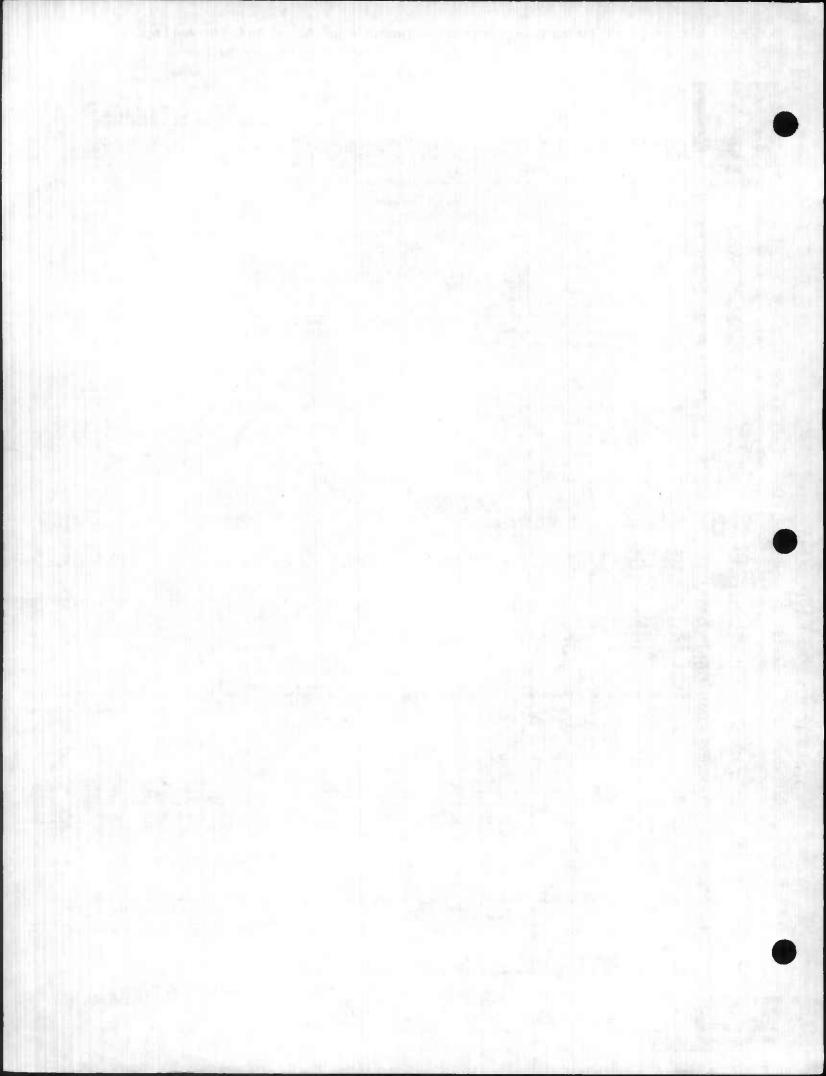


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State of Maryland / Department of Health and Mental Hygiene 00 26956

						Ce	ertifica	e of	Death		Reg. No.	O	400	00
		1. Decedent's Name	(First, Middle, La	st)						2. Date of D			3. Tima of	Death
	Physician	TOD.	D JAC	K PE	TERS					Month 08	Day 08	Year	03:18	PM
	/Medical	4a Facility Name (If I							4b. City, Town, or	1	ith 4c. Count	y of Death		- /
	Examiner	HARFOR				SPITI	Al		HAVRE D	E C.RAC				
- 100		5. Social Security Nu			7. Age (In yrs		7 1177	r 1 Year		s. 8. Date of B	irth			r Foreign
	Funeral Director	214-66-3		120 M 2□ F	45	Yrs.	Months	Days	Hours Min	Feb. 2	1955	Mar	place (State o	. r oroigir
-		Uauai Residence of D								100.	-		7	
	land tand	10a. State	10b. County		10c. C	ity, Town or	Location						10d. Inside Ci	ty Limits
	the Marylar 28a-f show notified at sector	MD	Harfo	rd		Aberd	leen						t ∑ Yes	2 No
	with the Maryla or 28s-f shor be notified at Director	10e. Street and Numi	ber				10f. Zi	o Code			10g. Citizen of	What Cou	intry?	
	with page 1	606 Pine	Lane					210	01		U.S.A.			
	n 23a	11. Marital Stetus	Luic	12 Was Dec	edent Ever in U	JS 13	Wes Dece			Specify Yes or N			ican Indian,	
	free death v r hems 23a ninet must		1			,,,,	If Yes, spe	city Cub	Hispanic Origin? (an, Mexican, Pue	rto Rican, etc.)	Bie	ck, Whita		
20	Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinat must be notified at page. To Be Completed by Funeral Director			1 Yes If Yes, Gir Year or D	ve		1 Yea	2K) No	Specify:		Speci	y: Wh:	ite	
Ş			15. Decedent's Ed		4100.	16a. Decedent's Usual Occupation					16b. Kind of F			
15		(Specify	y only highest gra	ide completed)		(Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Businass/Inde			
12		Elementary/Second	dary (0-12)	College (1-4or 5+)	Truck driver					Delivery			
B		17. Father's Name (F	irst Middle Last			18. Mother's				r's Name (First, Middle, Maiden Sumeme)				
an		Glenn C.									beth A. Fisher			
3						401.00	***	(0)					- 0-4-1	
Ma		19a. Informent'a Nan							t end Number or F					
		Mr. Glen			0.00				Ave., G		en Burnie, MD 21061-19 Date 20c. Location - City or Town, State			,
o o		20a. Method of Dispo		Removal from	Ctata	Place of Dis cemetery, cr	remetory or	other ple		Date				
Ē		1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) R. A. Ferris & Co., Inc. 8/9/00 West Cheste										r, PA		
at		21. Signature of Fund	Signature of Funerel Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A.											
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		23a. Part1. Enter the shock, or heart	disease, or com	plicetions that	used the dee	th. Do not e							Approximate	9
O	Physician	shock, or heart	tallure. List only	one cause on	ech line.							1	Onset and I	Death
n	/Medical	Immediate Cause (F												10110
	Examiner	disease or condition resulting in deeth)	disease or condition resulting in deeth) a. LYMPHOMA (BURKITIS)											
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	and and li-tre	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate												
09	2 Polo 2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):												
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~ E	The la page page									10	Yes 2 No	1	☐Yes 2☐	No
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7 5	After fune	1 Natural	5 Pending		of Injury th, Dey Year)	injun	M	28c. fnju Wo	rk?]Yes 2□No					
Division	tal or Attanding P rs shar death. al Director: After t led in by the funers Certification:	2 ☐ Accident 3 ☐ Suicide	investigation		4.1				1100 2 1100	204 Leastion	(Street and Num	har or Ou	mi Douto Alum	hor
Division	or At after Direction by	4 Homicide	determined	200. Piece	of Injury - At i	ify)	street, tacto	ry, office			own, Stete)	Der or nu	rei Noute riun	1001,
	pital ours a coral of filled					E I S								
	ne Hospi n 24 hou ne Funer pletely fill edical	29a. Certifier (Check only 2	Certifying Ph Medical Exam	ysician: To the	best of my kn	owledge, dea	eth occurred	at the ti	ime, date and pled opinion, death occ	ce, and due to the	e ceuse(s) and n	nanner as	steted. to the cause(s	()
	Within 24 hours of the Funeral completely filled	one)		end man	ner steted.									
	To the	29b. Signature and ti	11 11	۸			29	c. Licens	se number		29d. Date sign		, Day, Year)	
		1	Jacobia	yan/	70			D 45	5344		8/8/6	00		
	7	30. Nama and address	sa of person whe	completed caus	se of death (Ite	m 23a) (Typ	e, Print)							
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	State	31. Date filed (Month		32. F	legistrar's Sign	ature	1	1	MINGE W	- Unive	1 112	-10/		
	Registrar		AUG 10 2		Senew	1	9.	000	161					
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Poughkeepsie Frederick August 8 0125 Howard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Jan. 31, 1921 Mary Land 7. Age (In yrs. last birthdey) Months Days Hours XXM 2 F 79 Yrs. 215-16-2850 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥¥Yes 2□No Harford Aberdeen Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code w 23a or 2 must be n 643 Brenda Lane 21001 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 XYes 2 No ff Yes, Give Year or Dates 1942-46 1 Never Married 2 Married 8 Maryland 21215-0020 1 Yas 2000 Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Civil Service U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) 1 and 2 should be Health and Mental Annabelle Miller Frank Poughkeepsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) of Health of Health Jean A. Poughkeepsie (Spouse) 643 Brenda Lane Aberdeen, Maryland 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete R. A. Ferris & Co., Inc. 8/9/00 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Tarring—Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 Approximate Interval Setween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to for as a conseq Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant presentributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 → Unknown ρΛ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Pough 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury at Work? Affer or Attending Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after deatl 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral L Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edicai 29d. Date signed Month Day, Year

Registrar DHMH 16 Rev 6/95

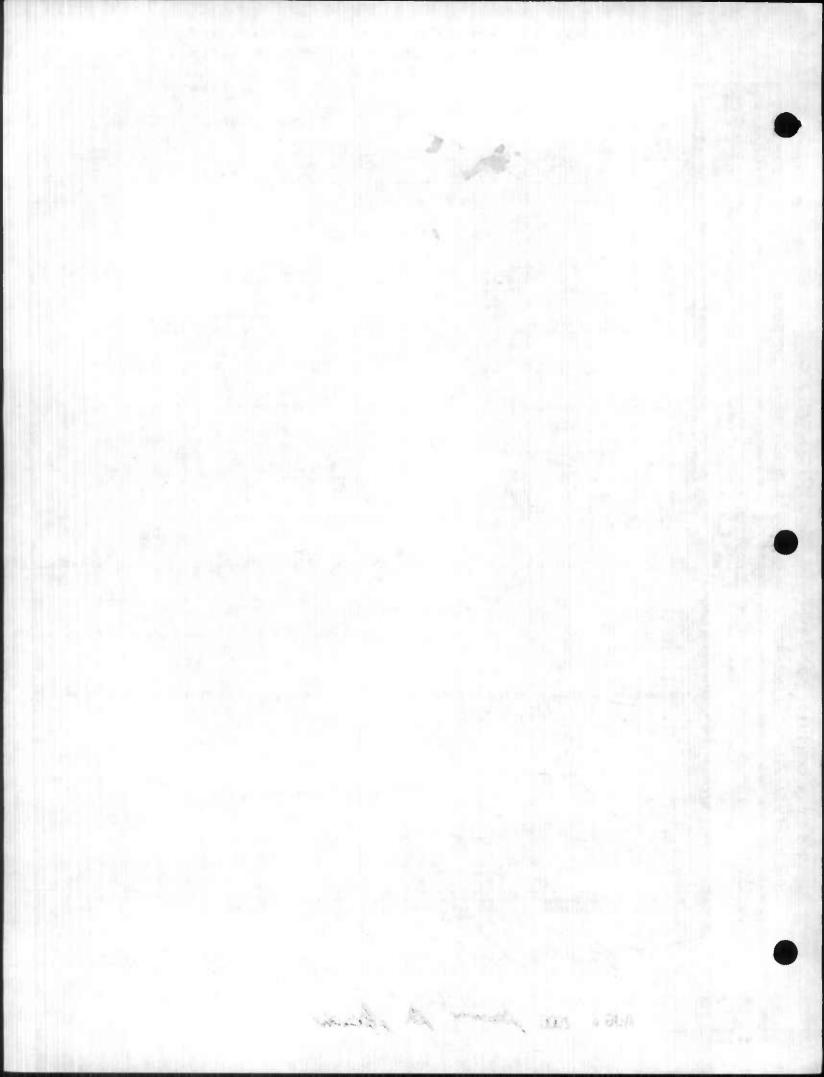
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31. Dete filled (Month, Dev. Yes

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Keepsie



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** PERKINS LAUZA JEAN Aug 10=25AM 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ICU FALLSTON GENERAL HOSPITAL HALFOND If Under 1 Year | Months Days Sex 1□ M 2∏ F 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 44 Director 220-72-0744
Usuel Residence of Decedent May 7, 1956 New York 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23s Funeral 3450 Albantowne Way 21040 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1□ Yes 2□No Specify: P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) 10 Cashier Retail Sales Pages 1 and 2 should be filed nent of Health and Mental Hyginnt: If Item 27 is marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leonard Douglas Nielsen, Marion Viola Woods 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: if Item 27 is. any injury or other trau 3450 Albantowne Way, Edgewood, Maryland 21040 Keith A. Perkins-Husband 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Carmel Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) 8/7/00 Mt. Emmorton, Maryland 22. Name end Address of Facility hure of Funeral Service Licenses McComas Funeral Home, P.A. the man disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the cause on each line. 21009 Approximete tritervat Between Onset and Death Physician tmmediete Cause (Finel diseese or condition resulting in death) /Medical ASCUD Examiner Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting to the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions of the condi Due to (or es a consequence of): Physician/Medical that initieted events resulting in death) Last Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 15 Yes 2□ No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 250No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 | Yes 2 | No Invastigetion 2 ☐ Accident 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 D Homicide hours. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

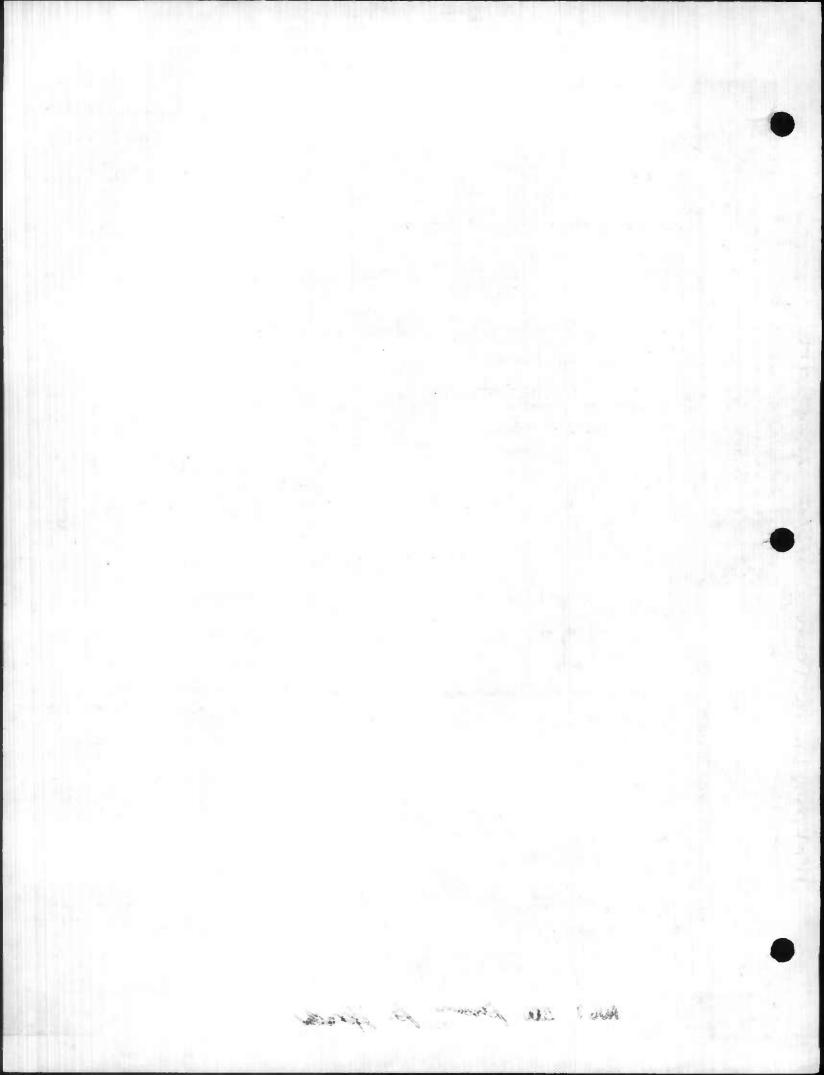
Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) To the Ho within 24 r To the Fur 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DME OCME 2000

State Registrar 31. Date filed (Month, Dey, Year) AUG 7 2000 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NABHU

TZ8BELAIR MD BELAIR MD 21014
strar's Signature



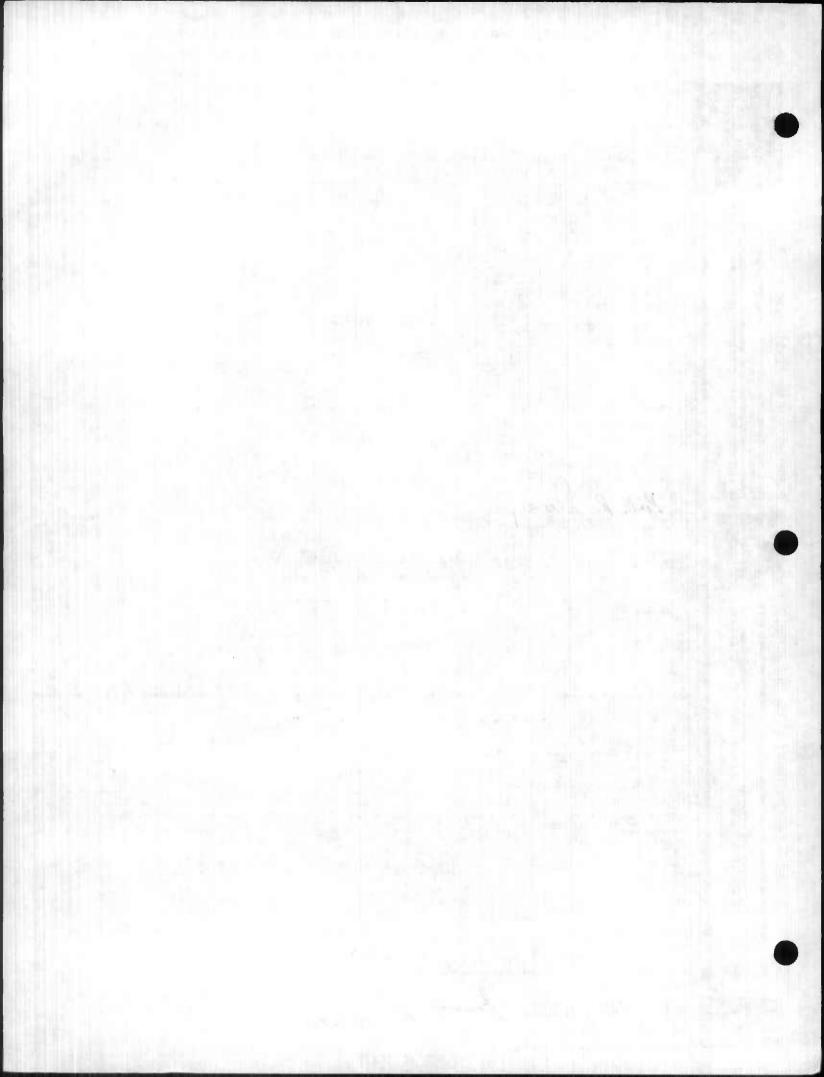
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State of Maryland / Department of Health and Mental Hygiene

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26959

				Certificate of	Death		Reg. No.			
Physician	Decedent's Name (First, Middle, JOSEPH		PERNAL			2. Date of Do Month Augus	Day	Year OO	3. Tima of Death 7:30 PM	
/Medical Examiner	4a Facility Name (If not Institution,	give street and number)		4b. City, Town,	or Location of Deal				
LAGIIIIIei	229 Canal Park	Dr., Unit	202		Salisk	oury	Wicon	nico		
Funeral Director	5. Social Security Number 083–14–0023	6. Sex 7. A	ge (In yrs. last birtl	nday) If Under 1 Yea Months Days		in. 8. Date of Bi	24,1914	Count	ace (State or Foreign ry) Vork	
	Usual Residence of Decedent									
items 23e or 28e-f show iner must be notified at uneral Director	10a. State 10b. County Marvland Wicon	ni ao	10c. City, Town	or Location				10	ld. Inside City Limits	
or 28a-f	Maryland Wicon	111111111111111111111111111111111111111	Sali	10f. Zip Code			10g. Citizen of V	What Count	rv?	
10 P P P	229 Canal Park	Dr., Unit	202	2180)4	USA				
iner 23 iner must Funeral	11. Marital Status	12. Was Decedent		13. Was Decedent of If Yes, specify Cu	(Specify Yes or No		e - America	ın Indian,		
by E	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' ed 1 X Yes 2 If Yes, Give Year or Dates:		If Yes, specify Cu		erto Rican, etc.)	Specify	k, White, e	ite	
ted to	15. Decedent's		16a.	Decedent's Usual Occi	pation	wadda a	16b. Kind of Bu	usiness/Ind	ustry	
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	12	4+	Sa	afety Engir	neer		Drug I	abora	tory	
	17. Father's Name (First, Middle, L.					lame (First, Middle	, Maiden Sumam			
	John Pernal				Heler	n Barzn	ica			
	19a. Informant's Name/Relationship			Mailing Address (Street						
27.4	Barbara Pernal/	Wife		229 Canal F	Park Dr.	Unit 20		-		
nant of He ret: If New rry or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Spe		cemetery	Disposition (Name of r, crematory or other plury Cremate		8/7/00	20c. Location -			
importa any lojv	21. Signature of Funeral Service U	icensee		22. Name and Add Holloway	ress of Facility Funeral	Home Pro	fessiona	al Ass	sociation	
physician and strength and the purial-transit and call Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	a End	Due to (or as a co		erna le	unq			& mos	
iaw requires that the death certificate be executed as been signed by the attending physician and 2.2 should be detached for use as the burial-transit prieted by Physician/Medical Examilabilities.	that miniated events resulting in death) Last Due to (or as a consequence of):									
% × ×	- LIVEN (MC	tast ones	* ug			_				
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page 2	Dung	Liscone				10	Yes 2 No	1	Yas 2□ No	
- O	25. Was case referred to medical				26. Place of f	Death (Check only	ene)			
	examiner?	Hospital:	ent 2 ER/Out	patient 3 DOA	ther: 4 Nursin	./	idence 6 □Oth	er (Specify)	
2 2	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigs	28a. Date of inj (Month, Di	ury 28b. T	me of 28c. tnj jury W	ury at ork?		how injury occur			
To the Function Directors. After the completely filled in by the function. Medical Certification:	3 Suicide 6 Could no 4 Homicide determin	ned 289. Place of th	jury - At home, far tc. (Specify)	m, street, factory, office	9		(Street and Numb iwn, State)	per or Rura	Route Number,	
he Funera pletely fille edical (Physician: To the best xaminer: On the basis of and manner s	of examination and							
To the	29b. Signature and title of certifier	THE PLANT		29c. Licer	nse number		29d. Date signe	d (Month, I	Day, Year)	
P	Jum 5		ey ~ ~ ~	, ,	0003	599	8-7	-00	>	
DIMINK	30. Name and address of person w John T. Bulkele			Type, Print) bluff Rd.,	Salisbu	ury, MD 2	1801		THE STR	
State	31. Date filed (Monin, idan Yaar) 8		rar's Signature	61						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 8 Martha Elizabeth Quomony August 2000 12:50 PM 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Forest Hill Harford If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) April 5,1910 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Deys Months 1 M 280 F 90 Yrs. 214-26-2429 Maryland Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Harford Havre de Grace 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Strawberry Lane 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck White etc. 1 ☐ Yes 2 No If Yas, Give 1 Never Merried 2 Married 1 Yes 2 No Specify Specify: Black 305Widowed 4 □ Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker In home 6 0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ouilla McGaw Frances McGaw Banks 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Jackson (Son) 203 Spesutia Rd., Aberdeen, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ⊠ Buriel 2 □ Cremetion 3 □ Removal from Stete St. James Cemetery 8/14/00 Havre de Grace, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause or sech line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel 2 WKS diseese or condition resulting in deeth) Due to (or as e consequence ot): Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

28a-f ahow

Name 23a or

the Medical Examiner naunt be notified at

Director

Funeral

by

Completed

Be

the Manyland

72 hours after

permit. Pages 1 and 2 should be filled within 72 hours at Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or any injury or other traumatic avant, the Marked other than page.

Baltimore, Maryland 21215-0020

Box 68760.

P.0.

Division of Vital Records,

Examiner the 2 signed bed bed Hospital or Attanding Physician: The law requiras to 24 hours after death.
 Funeral Director: After this certificate has been signs.

Physician/Medical þ Completed Be Medical Certification: To

To the Hospital or within 24 hours aft To the Funeral Di completely filled in State

Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aludud 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☒ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28a. Dete of Injury (Month, Day Year) 1 Neturel 5 Pending Investigetion 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

29c. License number

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier Whinau.

0 32 600

879100

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

1100 Revolution St. Haure De Granto21078 Kammain Millam HD

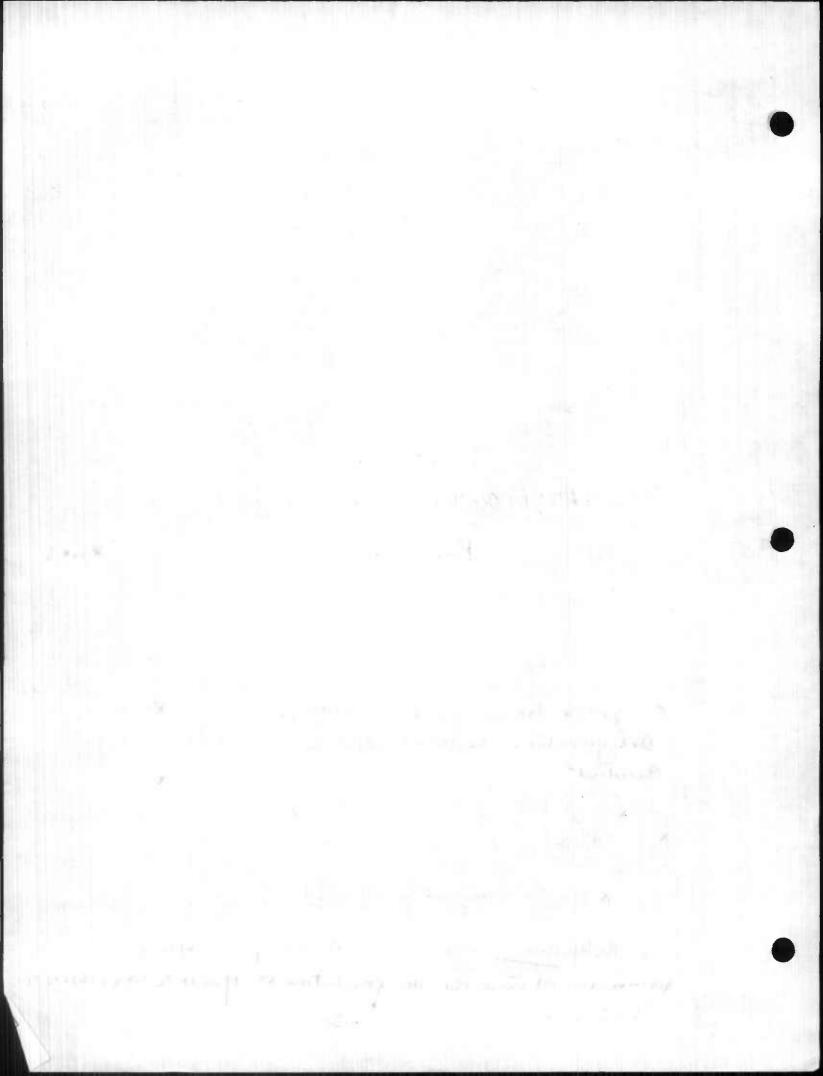
31. Date filed (Month, Day, Year) AUG 1 1 2000

4 Homicide

29a. Certifier (Check only one)

82. Registrar's Signeture

MM

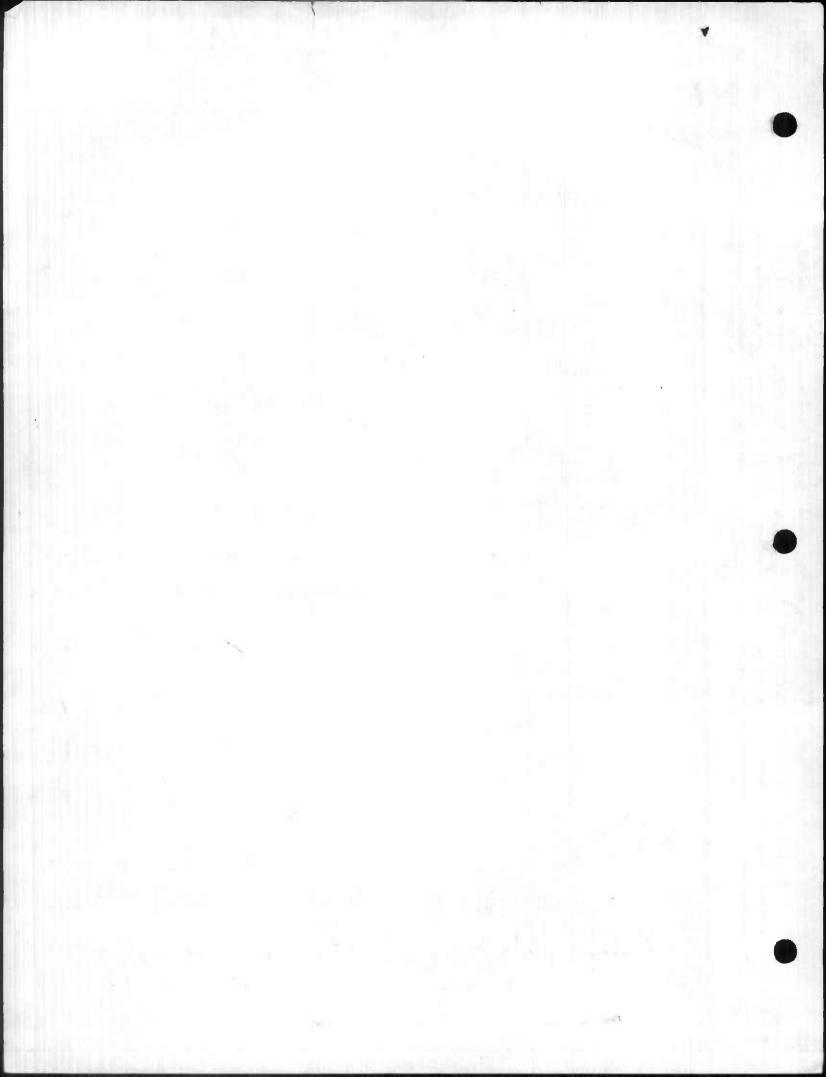


DHMH 16 Rev 6/95

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Registrar

AUG 1 0 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month **Physician** THELMA I. RUTLEDGE 8,2000 Aug. 6:15AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner 2529 Parliament Drive Abingdon Harford If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 1 □ M 200 Yrs. 89 7/12/1911 Indiana Director 307-30-1356 Usuel Residence of Decedent the Maryland 10c. City, Town or Location ahow 10a. State 10b. County 10d. Inside City Limits / in marked other than "natural", or flerns 23s or 25s-f show traumetic event, the Medical Examinar must be notified at 1 Yes No Director MD Harford Abingdon 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? with 2522 Parliament Drive 21009 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 전 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after Hygiene. other than "netural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: White py **X**Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Teacher High School 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 12 should be fill h and Mental H is marked off Be E. G. Reid Dovie Nevins 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is in any injury or other traum once. 2529 PArliament Dr., Abingdon, MD 21009 LouAnn DeZearn- daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, State 20a. Method of Disposition 8/12/00 Terre Haute 1 X Turial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Roselawn Mem. PArk Indiana 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility Harkins F.H. Inc. 600 Main St., Delta, PA plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Fart Veliter the cal Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Mys coms in Invacoson disease or condition resulting in death) Due to (or es e consequenca of) Examiner PAIT. DISCONE alongony certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last Due to (or es e consequenca of): Physician/Medicai Due to (or as e consequenca of): esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. the signed by t 1 ☐ Yes 2 PNo 3 Probably 4 Unknown ALZINGMER- TUPS Records, by 24b. Were autopsy findings evaileble prior to completion of cause of death? 24e. Was en eutopsy performed? Completed peen 1 Yes 1 TYes 2 No certificate Division of Vital Attending Physician: director, Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) 1 Yes 2 X Other: 4 Nursing Home POResidenca 6 Other (Specify) 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Neturel 5 Pending death. 1 Yes 2 No investigation or Attendiates of a Street of 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital of 24 hours a Funeral D **Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) To the To the To the 29d. Dete signed (Month, Day, Year) 29b. Signature end title of 29c. License number 20390 mo Aug. 08.2000 harle 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 0 Charles Hoesch, 9712 Bel Air Road, BAltimore, MD 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture

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DHMH 16 Rev 6/95

Registrar

AUG 9

2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth **Physician** Eldridge Wolff Rippons 1355 2000 AUGUST /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Cambridge

If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) Dorchester General Hospital Dorchester 5. Sociel Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) If Under 1 Year Birthpiece (Stete or Foreign Country) **Funeral** Months Deys 70 Yrs. Director Aug 8, 1930 Maryland 217-28-3559 Usuei Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. fnside City Limits Maryland Dorchester Hoopersville 1 Yes 20No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ns 23a or must be r 1750 Hoopersville Road 21634 US Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo ff Yes, Give Yeer or Detes: then "natural", or items the Medical Examiner ma Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White þ ₩Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) 11 . Pages 1 and 2 should be filed w ment of Health and Mental Hygler bant: if Nem 27 is marked other it jury or other traumatic event, the Waterman Seafood 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Thomas Cleveland Rippons Mary Adams 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Daughter 29639 Ferry Point Drive Trappe, Maryland 21673 Mary Virginia Collevechio 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete Dete 1X) Buriel 2 Cremetion 3 Removel from Stete Department or Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Old Trinity Churchyard 8/15/00 Church Creek, Maryland 21. Signature of Funerel Service Donnsee 22. Name end Address of Fecility Thomas Funeral Home, P.A. 23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Physician · ADENO CARCIMO UNKNOWN PRIMARY /Medical Immediete Ceuse (Finel 3 MOUTHS disease or condition resulting in deeth) Examiner a consequenca of):

HO hUNG and BLAN Examiner requires that the death certificate be executed physician and s the burial-transi Sequentietly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 88 usa Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? signed by the CARCINDINA 1 Yes 2 No 3 Probably 4 Unknown ROSTATE Division of Vital Records, à 24b. Were autopsy findings avellable prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed paga 2 s 1 Yes 20 No 1 ☐ Yes 20 No certificata e Hospital or Attending Physician: 24 hours aftar death. Funeral Director: Aftar this certifica ately filled in by the funeral director, i 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dev Year) 28c. fnjury et Work? 5 Pending investigation 1) Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29e. Certifier within 24 hou To the Funel complately fil Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner as steted. Medical (Check only one) 2 Medicat Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner steted. To the 29b. Signature end title of cartifier 29c. Licanse number 29d. Dete signed (Month, Dey, Yeer) august Name and address of person who completed cause of death (frem 2011) (Type, Print)

32. Registra/s Signeture

503 BYRD ST. CAMBRIDGE MD

21613

State Registrar

MICKAGZ 31. Dete filed (Month, Dey, Year)

AUG 1 4 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item#12 HCHD 8/15/00 bh Certificate of Death 2. Data of Death 3. Time of Death AUGUST Physician WILLIAM SAMPLES PONACO 10:33 2000 /Medical 4a Facility Nama (II not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FALISTON HOSPITAL FALLS TON HARTORD GENERAL If Under 24 Hrs. H Under 1 Year 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) NOV 3, 193 Birthplaca (Stata or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2□ F Director 1930 Tennessee 414-46-1954 **Usual Rasidence of Decedent** 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Directo Maryland Harford or 28a-1 Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 403 Barksdale Road 21085 Funeral USA 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 6 1 ☐ Yes 2 ☐ No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) U.S. Government College (1-4or 5+) Logistics Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) . Pages 1 and 2 should be fil ment of Health and Mental H lant: If Itam 27 la marked off jury or other traumatic avan Be Elva Goodwin Barrett I. Samples 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 403 Barksdale Road, Joppa, Maryland Janet Yoho Samples - Wife 21085 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Lenoir City Cemetery Lenoir City, Tennessee 8-9-00 22. Nama and Address of Facility
McComas Funeral Home, P.A. Comas 23a. Part1. Enter the disease, or complications that caused the cursh. Do shock, or liear failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, MD 21009 Approximata Interval Between Onset and Death 1. Do not enter the mode of dying, such as cardiac or respiratory arrast, **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical CORON ARY ARTERY DISEASE Examiner Due to (or as a consequence of): END STAGE REVAL DISCASE Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ISCHEMIC CAPDIO MY OPATH! Physician/Medical Dua to (or as a consequence of): VENTRICULAR TACKY CAPD IA 980 signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No HYPER CHOLES TEROL EMIA à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? HYPERTENSION page 2 1 Yes 20 No TOB 1 Yes 20 No certificate funaral director, Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Aural Route Number, City or Town, Stata) 3 4 Homicide filled in

VItai o Division

Donald

21215-0020

altimore, Maryland

Attending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely

State

Registrar

edicai

29a. Certifier

(Check only one)

29b. Signatura and titla of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Data signed (Month, Day, Year)

D0051209

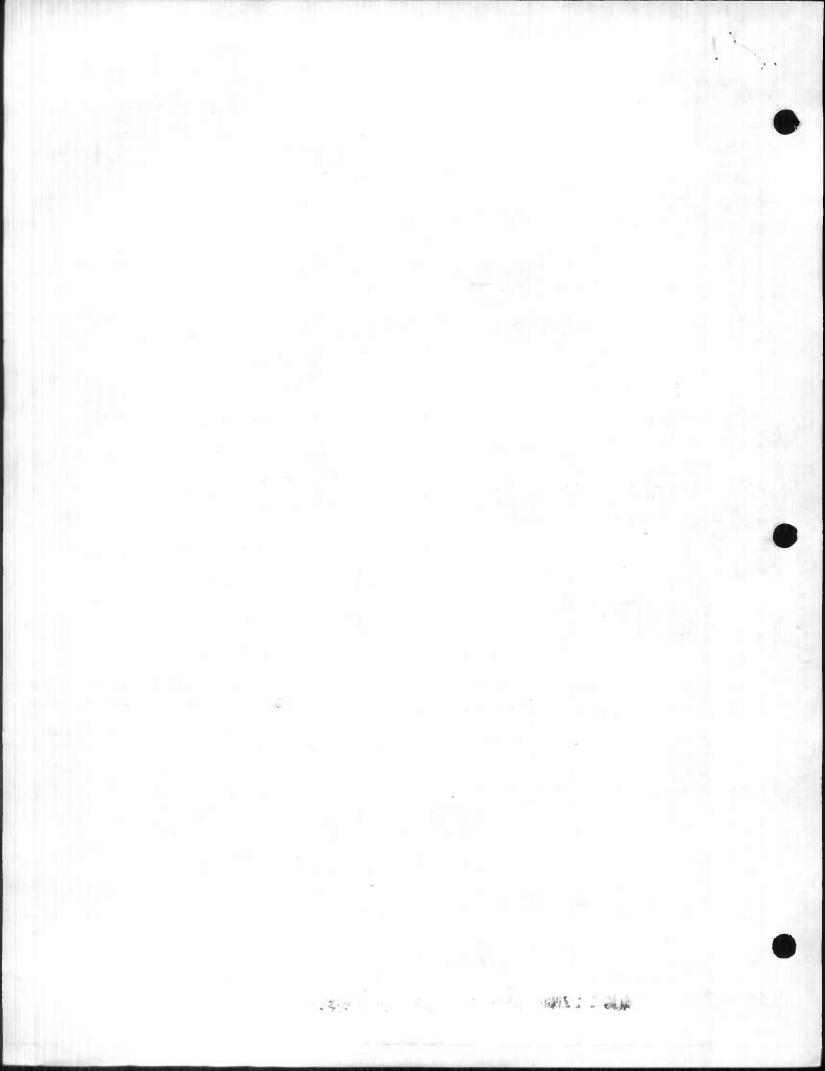
2000 AUGUST

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

LESTER LEUNG NEST MACPHAIL ADAD, SHITTE 206, BELAIN, MD 21014 615

31. Data filed (Man) Gay Year) 2000

32 Pegistrar's 6 ignature



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State of Maryland / Department of Health and Mental Hygiene 00 26965

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3a Part) Enter the disease or comm	plications that caused the	death. Do not an	317 Coke	sbury Ro	oad, Abin	gdon, Ma	aryland	1 21009 oproximata					
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b. Signature and Jitleyof certifier			29c. Licer	sa number		29d. Date signe	ed (Month, Da)	y, Year)					
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nt of Health and Mental Hygiene

			State of Maryland / Department of Health a
IMC	ELIZABETH	SLACUM	Certificate of Death

	1. Decedent's Name (First, Middle, La			ate of Death	2. Date of Deat	eg. No. h Day	3. Time of Death					
Physician /Medical	NAOMI	ELIZABETH	SLACUM		AUG.	8, 2000						
Examiner	4a Facility Name (If not institution, give				or Location of Death	4c. County	of Death					
	115 CHOPTANK		M the	CAMBRII			IESTER					
uneral irector		Sex 7. Age (In yr	Yrs. last birthday) If Ur Moni			8°999	Birthplace (State or Foreign Country) Maryland					
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at be notified at Director	10e. Street and Number 115 Chop	otank Ave.	10f.	Zip Code 21613	1	0g. Citizen of W U.S	hat Country?					
Examiner must Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		scedent of Hispanic Origin? specify Cuban, Mexican, Pu s 25 No Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, k, White, etc. - white					
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any inports	21. Signature of Edneral Service Lice	R Marry C		and Address of Facility Locust St. C								
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signed by the attending d be detached for use a d by Physician/M					1 D Y	ee 2□No	3 Probably ∰ Unknown					
s been s 2 should pleted				X	24a. Was a perfor	in autopsy med?	24b. Were autopsy findings available prior to completion of cause of daath?					
page 2						as 25 No	1 ☐ Yes 2 ☐ No					
ector. Be	25. Was casa rafarred to medicel examiner?	No. 20-4		0.1	Daath (Check only or							
T T	1X Yes 2 No 27. Manner of Death 1X Natural 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Time of	Other: 4 Nursin 28c. Injury at Work? 1 Yes 2 No	g Home 5 Reside		er (Specify) AT SCENE ed					
	2 Accidant investigation 3 Suicide 6 Could not to detarmined	De Place of Injury A	t home, larm, street, fa		28f. Location (S City or Town	treet and Numb n, State)	er or Rural Route Number,					
he Funeral plately fillo edical C		nysician: To the best of my k miner: On the basis of exami and manner stated.										
within 24 hours after deat To the Funeral Director: complataly filled in by the Medical Certifica	29b. Signature and title of certifier	1 1		29c. Licensa number	2	9d. Date signed	d (Month, Day, Year)					
	1 //	1 1/ 11	1	O.C.M.E	0 2000							
F 8	1//	- 1 / V. I.	7	O.C.M.E		AUG.	8, 2000					

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b. Sparks

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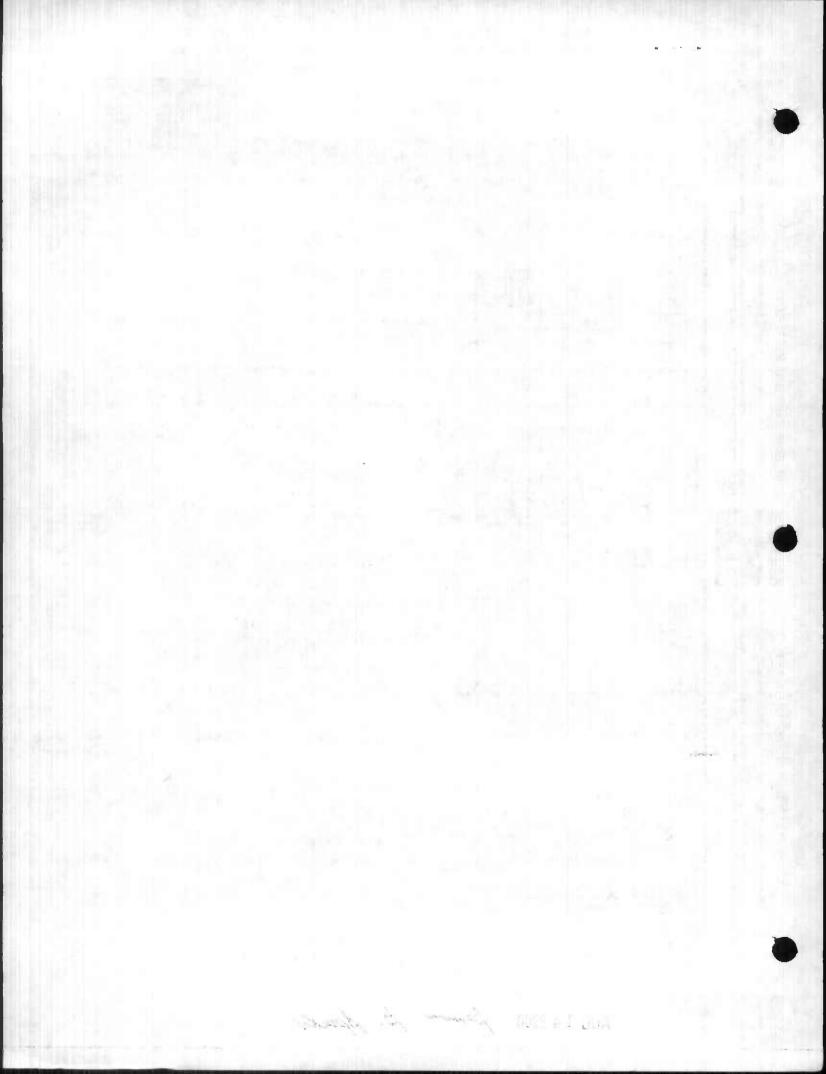
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Francis Shapiro Kay 4b. City, Town, or Location of Deeth 12,2000 /Medical 0010 4a Fecility Name (If not institution, giva street and number) 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiece (State or Foreign Country) **Funeral** 1□MXZF Yrs Aug 23, 1956 Director Maryland <u>214-68-5781</u> Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2□No Director Cambridge 288-4 Maryland Dorchester must be notif 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Berns 23a or US 1104 Glover Avenue 21613 Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indien, Bieck, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 Never Merried 2 Merried 1 Yas 2 No Kay Shapiro Maryland 21215-0020 B 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary Hospital 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) 89 8 Virginia Rose Bell Charles Dennis George, Jr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Retetionship (Type, Print) Pages 1 and 2 r Department of Health I Important: If Nem 27 is any Injury or other tra Maryland 21613 Jacqueline L. Gambrill Sister 1104 Glover Avenue Cambridge, Baltimore, 20b. Piace of Disposition (Nama of cematery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriei 2 Cremetion 3 Removel from Stete 4 Daneton 5 Other (Specify) Dorchester Memorial Park 8/15/00 Cambridge, Maryland 5 Other (Specify) 21, Signature of Funarel Sarvige Licensaa 22. Neme end Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23e. Pen /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, short, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Dilated Cardiomypathy Examiner years Due to (or as a consequence of) Examiner Adriamycin Toxicity years The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last bunial-trar Due to (or es a consequence of): and Metastatic Carcinoma of Breast 3 years Box 68760 physicien Physician/Medical es the t Due to (or es e consequence of): 980 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. P.O. 1 Yes 3 No 3 Probably 4 Unknown þ Records, cate has been significant page 2 should b 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? Completed After this certificate has 1 Yes 2 No 1 Yes of Vital spital or Attending Physician: The hours after deeth.

neral Director: After this certificate y filled in by the funeral director, pa Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Mepner of Death
12 Naturei
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner stated. 29a, Certifier Medical 29d, Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print) MD 403 Marvel Court Easton, Maryland 21601 M.C. Rajasingh, 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar

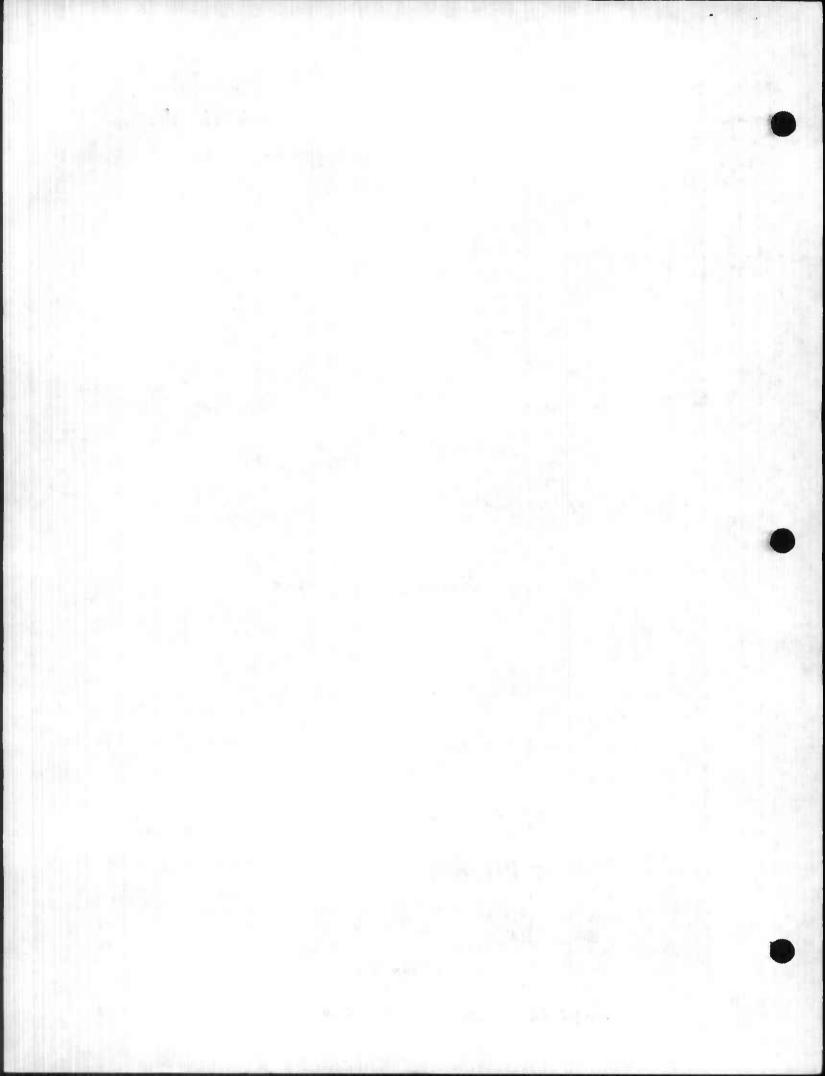
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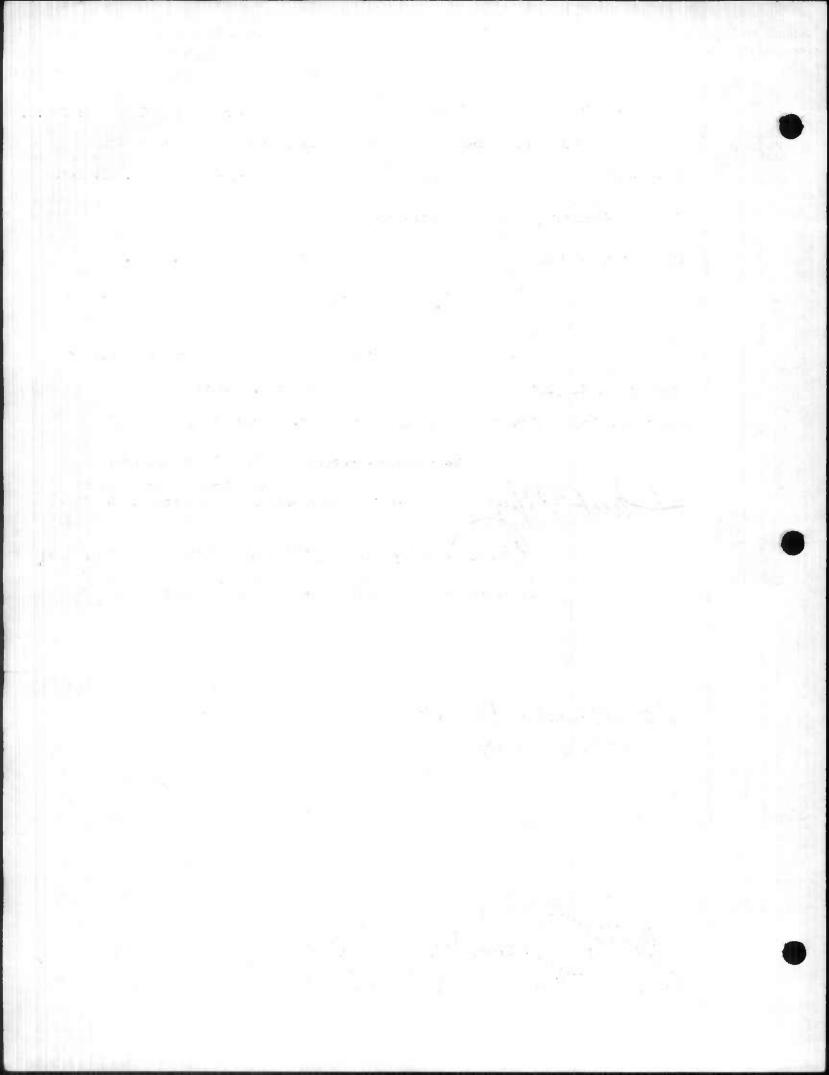
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Funeral Director	214 34 0439	7. Age (In yrs	Yrs. If Under Months	1 Year If Under 24 Hr. Deys Hours Mir			9. Birthplece (State or Country) Maryland	Foreign		
show dat	Usuet Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Location				10d. inside City			
eath with the Marylo in 23s or 25s4 shor must be notified at eral Director	Maryland Washir	ngton Ha	agerstown 10f. Zip	Code	10	g. Citizen of V	1 ☑ Yes 2			
w di ga	841 Summit Ave.			21740		USA				
her of the form	3√2 Widowed 4 □ Divorced	12. Wes Decedent Ever in I Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Detes:		ent of Hispenlc Origin? (ify Cuben, Mexican, Pue 없 No Specify:	Specify Yes or No- rto Rican, etc.)	or No- 14. Rece - American Indien, Bleck, White, etc. Specify: White				
72 ho	15. Decedent's Ed (Specify only highest gra		16e. Decedent's Usue	l Occupation k done during most of w	orkina 1	6b. Kind of Bu	usiness/Industry			
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and and	19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)						
dillimore, mit. Pages 1 ar partment of Hea portent; if Item; y Injury or othe	Vickie E. Noll 20e. Method of Disposition PD Burial 2 Cremetion 3 C 4 Donetion 5 Other (Specific	Removel from State Ce	dar Lawn Men	norial Park						
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The page	3 DIABETES MI	ELLATUS II			1 ☐ Ye	s 202 No	of death?	10		
certificate rector, pag	25. Was case referred to medical examiner?				eath (Check only one)				
수 하는	7.50		☐ ER/Outpatient 3☐ DO		Home 5 Resider					
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To the Hospital or Attending Is within 24 hours after death within 24 hours after death completely filled in by the funer completely filled in by the funer Medical Certification.		ysician: To the best of my kn niner: On the basis of examin end menner steted.	owledge, death occurred a ation and/or investigation,	at the time, date and place in my opinion, deeth occ	ce, and due to the ca curred at the time, da	use(s) and ma te and place,	nner as stated. and due to the cause(s)			
Me the	29b. Signeture end title of certifier	Vest U	29c	. License number	29		d (Month, Day, Year)			
		ed2 MD		D52055		8-08-00				
	30. Name and address of person who 2015AIR 27	completed cause of death (Ite	m 23a) (Type, Print) 8 MILL S	+ HAGE	estown,	ano	21740			
State	31. Dete filed (Month, Day, Year)	32. Registrar's Sign	eture 4	low Val						



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			Homewood	d Health	Care Cen	ter			Williams	port	Wash	ington	
Г	Funeral		5. Social Security N			Age (In yrs. last	Month	ler 1 Year s Days		8. Dete of Bir (Month, De	th v. Year)	9. Birthpla	ce (Stete or Foreign
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	eho	2	MD	Washing	ton		erstown					100	d. Inside City Limits 1 ☐ Yes 2 🖾 No
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	With Will						101. 2	Zip Code			10g. Citizen of		y7
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21215-0020	within 72 hours liene. r than "naturel", the Medical Exe	9		15. Decedent's Ed		IJTJ	6a. Decedent's Us	sual Occur	petion		16b. Kind of B	usiness/indu	atry
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any	& DEE		19e. Informant's N	ame/Relationship (Type, Print)	1:	9b. Meiling Addre	ss (Street	t end Number or Rui	rai Route Numb	er, City or Town	Stete, Zip C	Code)
			Shelia Je	an Weaver	c / Daugh	ter 1	8125 Cle	arwa	y Dr. Ha	gerstow	n, MD	21740	
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	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	led	one)	- I I I I I I I I I I I I I I I I I I I	end menner s	teted.	т-			iou or me time,			
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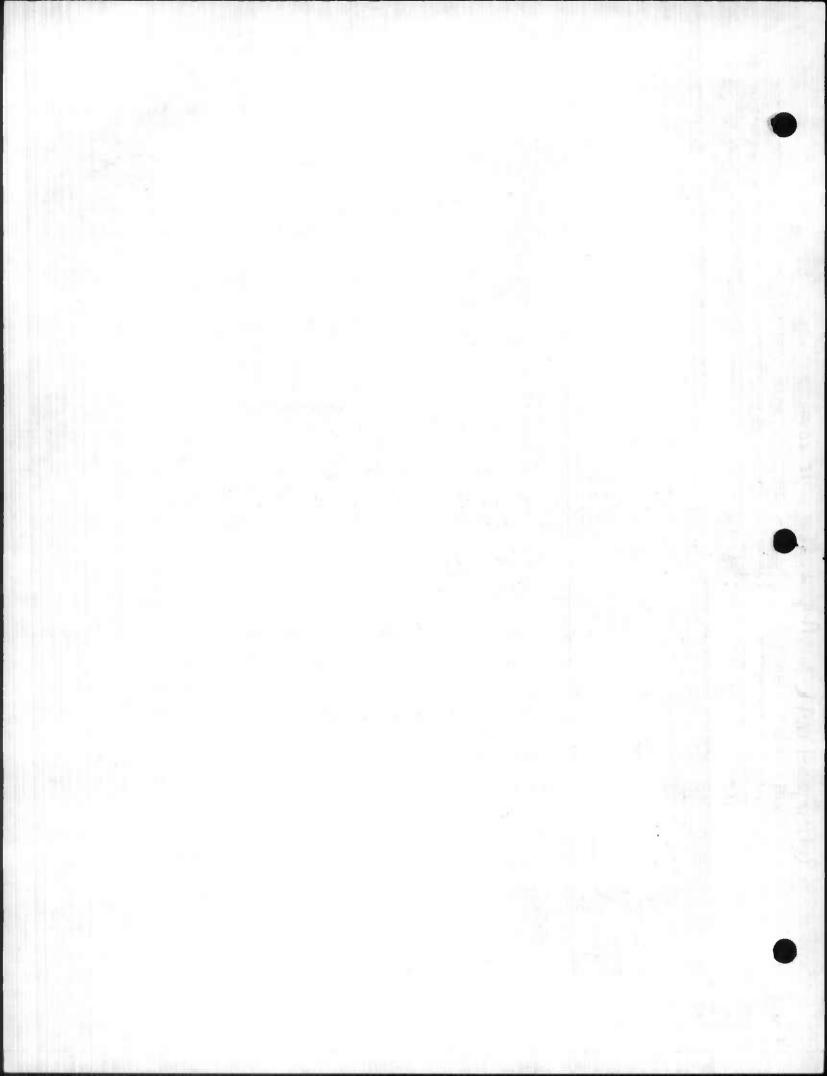
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Director		225-94-9624	1□ M 2ØF	86	Yrs.	Months Days	Hours Mili	5/15/		Virgi	
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and Meda		19a. Informant's Name/Relationsh	ip (Type, Print)	1:	9b. Maitin	g Addrass (Street	end Number or F	Rural Route Num	ber, City or Town,	Stete, Zip	Code)
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SEE		Dri. / 1 A	moll.	14	H	olloway :	Melson F	uneral	Home, P.	A.	
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9 8	Physician/	Part II. Other significant condition	s contributing to death	but not resulting	in the un	derlying cause giv	ven in Pert I.	23b. Dk	d tobacco use co	ntribute to	the causs of death?
ite has been signed by the page 2 should be detached	듄							10	Yes 20PNo	3 Prob	ably 4 Unknow
5.8	P							-			
been signature of the s	Completed							24a. Wa	s an autopsy formed?	ava	re autopsy findings litable prior to
has be	pie						1/200			of c	npletion of cause laath?
ate ha	E O							10	Yas 2 3 No	1 🗆	Yes 2□ No
	Be	25. Was case referred to medical					26. Place of De	eath (Check only	one)		
	0	axaminar? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 ER/	Outpatien	3 DOA Oth	ner.		sidence 6 Oth	er (Specify	()
eral d	-	27. Manner of Death	28a. Date of In		. Time of	28c. Injui			how Injury occur		
Attending or death. ector: After by the fune	을	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident Investig		ey rear)	Injury		Yes 2 No				
ctor cy th	Certification:	3 Suicide 6 Could n	and 200. Placa of II	njury - At home,	farm, stre	el, factory, offica		28f. Location	(Street and Numb	er or Rura	Route Number,
Dir.	err	4 Homicide	building, a	ic. (Specify)				City or 1	own, Stete)		
within 24 hours of the funeral completely filled		29a. Certifier 1 Certifying	Physician: To the bes	t of my knowled	ne death	occurred at the tir	me date and plac	e and due to th	e cause(s) and ma	annar as et	aled
Fun etely	edicai		xaminer: On the basis and manner s	of examination	and/or inv	astigation, in my o	ppinion, death occ	curred at the time	o, date and placa,	and dua to	the cause(s)
within to thous after death. To the Funeral Director: After completely illied in by the funeral		29b. Signature and title of certifier	and manner of			29c. Licens	se number		29d. Date signe	d (Month, I	Dey, Year)
- ≯ ⊨ 8			1	2 0		1 ^ -			00/:	/_	
		Jan 9	and IV,	1.0.		250	759		08/16	100	
		30. Nama and address of person w	no complated causa of	death (Item 23)	(Type, I	Print)		00	CN ICAL.	/ I ha	0 2/80/
		CHAKLES FO	LASHADE	MD	108	PINEB	WEFF	RD.	MANGU	7 11	10) 2180/
Stat		31. Date filed (Month, Dey, Year)		trar's Signature	6	1	1				
Registra	ır	AUG 17	2000	and the same	D.	poort	2				

4296-46-4624

Wood, Mabel R

State of Maryland / Department of Health and Mental Hygiene

			State o	f Mary		partmer <i>ertifica</i> :		lealth and I Death	Mental Hy	giene	00	26971
	1. Decedent's Name	e (First, Middle, L	ast)						2. Date of D	eath		3. Time of Death
Physician	Ruth B	. Wise							Augu	Day	2000	1030 Am
/Medical Examiner	4a Facility Name (h	f not institution, g	ive street and nu	mber)				4b. City, Town, or			ity of Death	100-1111
	Fallsto	n Genero	el Hospi	tal				Fallston	ı	Hav	ford	
Funeral	5. Social Security N		Sex	7. Age (In	yrs. last birthde	(y) If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Dale of Bi (Month, D. Nov. 1	rth	9. Birth	place (State or Foreign
Director	150-32-4		1□M 2X F	5	8 Yrs.	Months	Days	Tiours Will.	Nov. 1	1,1941	New	Tersey
P	Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town or	Location						Od. Inside City Limits
r aho	Maryland	Harfor	d			est Hi	99					1 ☐ Yes 2 ☑ No
vith the Ma s or 28s-f a be nouns	10e. Street and Num		<u> </u>		10/2	101, Zi				10g. Citizen o	(What Cour	
	10 K Loc	khart Ci	ircle					050			I.S.A.	,
Other deeth in thems 23 other men	11. Merital Status		12. Was Dece Armed Fo	edent Ever	in U,S. 1:	3. Was Dece	dent of F	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or N	o- 14. R	ace - Americ	
20 attar dee or flems miner m	1 Never Marri	ed 2D Married	1 Yes	2 XNo		1 ☐ Yes			io Fican, atc.)		leck, White,	white
5-0020 72 hours after meturel; or fe	3 Widowed	4 Divorced	Year or D	etes:		10,165	25(110	Specify.		Spec	ary:	wille
15-002 172 hours natural;	(Spec	15. Decedent's E ify only highest g	Education rade completed)		(Gi	cedent's Usu ve kind of wo	ork done	during most of wor	rking	16b. Kind of	Business/In	dustry
1 21215-0 ed within 72 ho vyglene. er than "natur ft, the Medical Completed	Elementary/Second	ndary (0-12)	College (1	I-4or 5+)		eacher		9)		Educ	ation	
d Hand	17. Father's Name (First, Middle, Las				euche		18. Mother's Nar	me (First, Middle			
altimore, Maryland 21215-0020 mit. Peges 1 and 2 should be filed within 72 hours aft partment of Health and Mentel Hyglene. portant: If frem 27 is marked other than "natural", or y injury or other traumatic event, the Medical Feen sa.	Theodor		ilehem					Agnes	Gare	y		
Mary Mary and 2 shou th and W T 10 mar treumai treumai	19a. Informant's Na	me/Relationship	(Type, Print)		19b. Ma	iling Addres	s (Street	and Number or Ru	ural Route Numb	per, City or Tow	m, State, Zip	Code)
M, M	Leonard	A. Wise,	III	(son)				t Circle,	Forest	Hill,	MD 2	1050
nore, and more, and of Hensell in Whem	20a. Method of Disp	Osition	□ Removel from	State 2	Ob. Place of Dis	position (Na remetory or o	me of other plea	00)	Date	20c. Location	- City or To	own, Stete
timent function		5 Other (Spec		State	Green M	ount (remo	utory	8/4/00	Baltin	nore,	Maryland
Baitimore, Maryland 212 Beattimore, Maryland 212 Pemit. Peges 1 and 2 should be filed with Department of Health and Mentel Hyglene, Important: If flem 27 ie marked other than eny injury or other traumate event, that page. To Be Comp	21. Signature of Fu	neral Service Lice	ensee	00,1		Schim	unek	ss of Focility Funeral cPhail R	Home o	Bel A	ir, II	nc.
0	23a. Pert1. Enter the shock, or hear	ne disease, or con	mplications that c	aused the	death. Do not e	enter the mod	de of dyir	ng, such as cardia	c or respiratory	errest,	210	Approximate Intervel Between
Physician /Medical Examiner	Immediate Cause (I disease or condition resulting in death)		. Se Bes	pira	to (or as a cons	Fail	ur	e_				Onset and Death
Ox 6876(certificate be iding physicis ise as the but	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L		o. 05-	teor Due	to (or as a dons Nyeli't to (or as a cons espire	equence of):	Di	stress	Synd	rome		
2 · 0 · 0	Part II. Other signifi	cant conditions	contributing to de	eath but no	t resulting in the	underlying o	cause giv	ren in Pert I.	23b. Did	tobacco use	ontribute t	o the cause of death?
IS, P.O se thet the be deteched by Phys	Seu	ere Co	vonan	1 ais	tery o	disco	rse		10	Yes 20 No	3 Pro	bably 4 Unknown
Record Record le law requir hes been s se 2 should mpleted	Dia	betis	Me	Iltu	is				perf	s an autopsy ormed?	av co of	ere autopsy lindings allable prior to implation of causa death?
	25. Was case refer	ed to medical	1					26 Place of De			- "	Tes Silve
7 > 10 mg	examiner?		Hospital:	npatient	2 ER/Outpat	ient 3 D	OA Oth	26. Place of De	toma 5 ☐ Res		Wher /Sneci	(v)
Physicial Properties	27. Manner of Death		28a. Date (-			28c. Injur		1	how injury occ		,,
Vision Attending Rector: After by the fune	1 (Affatural 2 Accident	5 Pending investigation	on	n, Day rec	ar) Injun	М		Yes 2 □ No				
Division of the standing P is after death. al Director After the death of in by the funer.	3 ☐ Suicide 4 ☐ Homicide	6 Could not l	28a. Place buildin	of Injury - ng, etc. (Sp	At home, ferm, pecify)	street, fector	y, office		28f. Location City or To	(Street and Number, State)	nber or Run	al Route Number,
College	00 0 00											
Division To the Hospital or Attendin within 24 bours after death. To the Funeral Director Att completaly filled in by the fur	29a, Certifier (Check only	2 Medical Exa	miner: On the ba	best of my asis of examer ner stated.	r knowledge, de mination and/or	ath occurred investigation	at the tir i, in my o	ne, date end place pinion, deeth occu	e, end due to the urred at the time,	cause(s) and , date and plec	manner as s a, and due t	tated. the ceuse(s)
To the composition of the compos	29b. Signature and	title of centifier	Attac	42 4	A G	29	c. Licens	e number		29d. Date sig		
	P 10	100	111111111111111111111111111111111111111	ALL IV	7		J.	16444		Hugu	ST 30	42000.
15	30. Name and addre	ess of person who					IR	ROAD	. PAL	LSTO	v. M	D21047
State Registrar	31. Date filed (Monti	N. Day, Year)		Sgistrar's S	Signeture	. 14	park	2				



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BALTIMORE, MARYLAND 21215-002	. Page 6 may be retained by the hospital or attending phy
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2	Page
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20	after
	hours

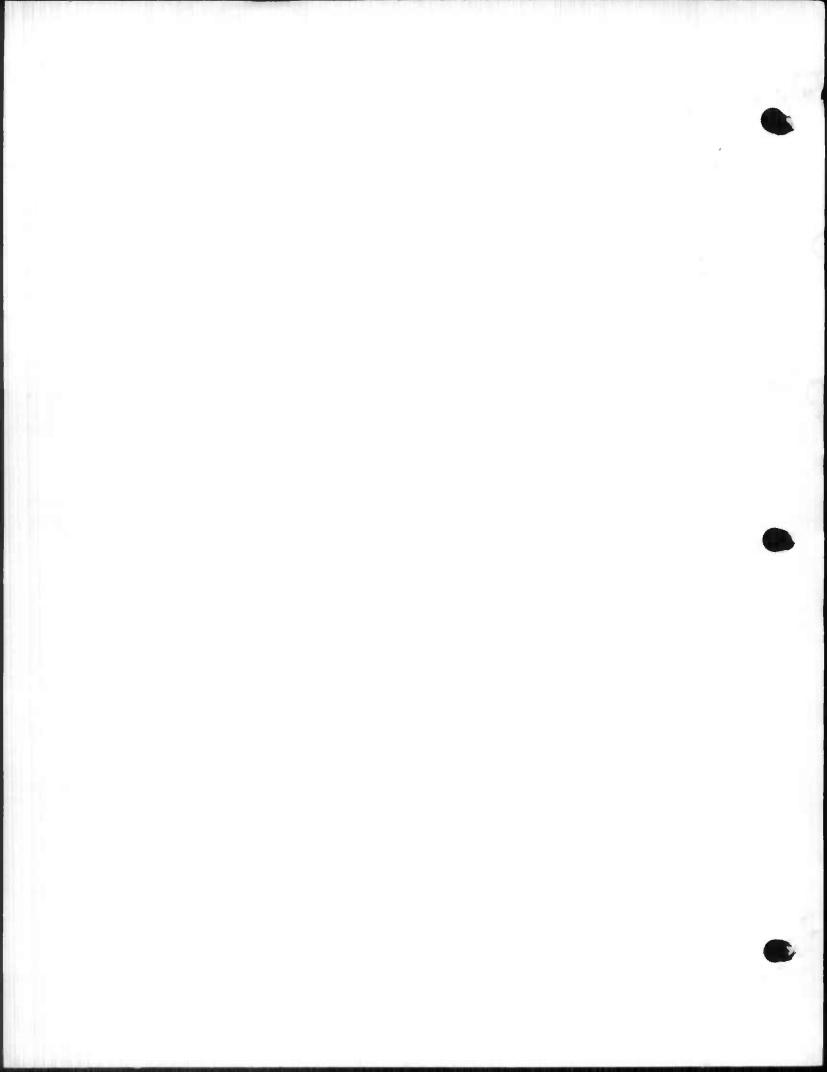
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to brinkil, ceruation, or removal.

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

		1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
		Violet	Mar	rie Wir	sing						August 7	20)00	7:10 P.M.
		4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yrs.	last birthday)		ER 1 YEAR	IF UND	ER 24 HRS.	7. DATE OF BIRTH		8. BIRT	HPLACE (State or Foreign
		216-12-7500	-	1 🗆 M 2 🔯 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 9, Year)	912	Peni	Tsylvania
		9e. FACILITY NAME (If not ins								TION OF D	EATH		NTY OF E	
	DIRECTOR	539 Aldino		ney Road			A	berde	een			Ha	rfor	rd
	គ្ន	RESIDENCE OF DEC	10b. COUNTY	1		10c, C/1	TY. TOWN	OR LOCAT	TION					10d. INSIDE CITY
- 1	S	Maryland	Har	ford				deen	1011					LIMITS?
	RAL	10e. STREET AND NUMBER						101	. ZIP CO	0E		10g, CIT	IZEN OF V	WHAT COUNTRY?
	ER/	539 Aldino	-Stepn	ey Road					21	001			U.S.	
	FUNE	11. MARITAL STATUS		12. WAS DECEDEN			13				NIC ORIGIN? (Specify Ye	s or No—	14. RAC	E — American Indian,
	BY	1 Never Married 2 1 1 3 Wildowed 4 Divor		IF YES, GIVE Y	YES 2 TO WAR OR DATES	₫NO.		1 YES			in, Puerto Rican, atc.)		Spec	k, White, etc.
		141	DENT'S EDU	CATION	1200									White
	ETE	(Specify only	highest grade	completed)		DECEDENT'S (Give kind of the. Do NOT u	work done	durina mo		king	16b. KIND OF BU	SINESS/INI	DUSTRY	
		Elementary/Secondary (0-	12)	College (1-4 or 6	+)	Homer		•			In ho	me		
once.	COMPL	17. FATHER'S NAME (First, Mic	ddle, Last)						18. MO	THER'S NA	ME (First, Middle, Maiden	Surneme)		
75	ш	Elmer Shen	k						1	Mabe.	l Dettinge	r		
-	0 B	194. INFORMANT'S NAME (Ty		-							Route Number, City or Tox			1040
be m	-	Larry Park		indson)						Road	, Conowing			1918
must		1 Donation 5 Other	n 3 🗆 Reme	oval from State		rematory of o				'emet	.8/11/00 A	cation – berda	City or To	own, State
ner	j	21. SIGNATURE OF FUNERAL		ENSEE	100.		22	. NAME AN	ND ADDR	ESS OF FA	CILITY			
examiner must be		- hisset	7 Am	MILIDE	Veste	1.		Tarr: Aber	ing- deen	Cargo Ma:	o Funeral ryland 21	Home, 001-:	3399	A.
medical		23. PART I. Entar the dis	seases, or o	complications the	t caused the	lesth. Do								Approximate
E		IMMEDIATE CAUSE (Fine		List only one cau	rse on each lic	na.								Interval Between Onset and Death
the the		disease or condition resulting in death)	*	ASC	200									15105
event,	1			DUE TO	(OR AS A CONS	EOUENCE O	MF):							111
	S	Sequentially list condition	ons,	HCV	[/									20 45
other traumatic	F	if any, leading to immed cause. Enter UNDERLYIM	lata	OUE TO	(OR AS A CONS	EQUENCE O	IF):							
her		CAUSE (Disease or injur		DUE TO	(OR AS A CONS	EQUENCE O	F):							
6	CERTIFICATION	resulting in death) LAST		d										
25	- 1	PART II. Other algolfican	nt condition	s contributing to	death but not	resulting	In the re	nderlyln	COLLOG	alven in	Part I. 24s. WAS AN	ALITONOV	100	. WERE AUTOPSY FINDINGS
amy In	MEDICAL							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9 00000	given in	PERFO	MEO?	240	AWAILABLE PRIOR TO COMPLETION OF CAUSE
shows a	요								1		1 TYES	MO		DF DEATH?
5 '	- 1	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF DE	ATH YI	ES 🗆	NO T	UN	CERTAII	<u> </u>			1 YES 2 AG
Item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?				ACE OF OEA	TH (Check	(only one)						
or It		1 TYES 2 17 16		HOSPITAL:	ER/Outpatient	3 DOA	OTHE 4 □ Nu	R: Insing Hom	• 5 DV	residence	6 Other (Specify)			
Ked.	PHY	27. MANNER OF DEATH 1 Natural 5 P	ending	28e. DATE OF (Month, D	INJURY ley, Year)	28b. TIN	E OF JURY		RK?		28d. DESCRIBE HOW	NJURY OC	CURED	
	ā	2 Accident In	vestigation	26a, PLACE O	F INJURY — At I	Yorne form			rES 2	⊔ NO	and Location (Owner			
2	TED		could not be etermined	building,	etc. (Specify)	ronna, ranni,	otroot, rat	orony, orner			City or Town, State)	ena Number	or Hurei i	noure Number,
ltem	PLET	290. CERTIFIER	FYING PHYSIC	CIAN: To the best of	my knowledge	leath occurr	ad at the	time date	and plac	a and due	to the cause(s) end ma		Lia.	
INT: If	COM													s) end manner es stated,
POR P	BE	296. SIGNATURE AND TITLE	OF CENTIFIES	(MP)					29c. LI	CENSE NUM	ABER A	29d. DAT	E SIGNED	(Month, Day, Year)
- 5	2	30. NAME AND ADDRESS OF	PERSON WHO		SE OF DEATH (IT	ЕМ 27) (Тура	Print)				•			
			stein			s. Un	ion	Hue	- H	auec	deGrac	e.M	D.	21018
		31. DATE FILEO (Month, Day, N	0		R'S SIGNATURE	B.	1	bou	6/		-			
									_					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Anna Wells 80 05 2000 3am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home, Inc. Denton Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 22,1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1□M 2以F Yrs. 212-01-9596 **Director** Maryland Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Caroline Ridgely 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 13027 Crouse Mill Road 21660 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: PV White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Seamstress Clothing Manufacturer 6th Grade permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic avent anse 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Stanislav Klapka Anna Svejnoha 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Nancy L. Harrington (Niece) 13027 Crouse Mill Road, Ridgely, Maryland 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bohemian National Cemetery 8/8/00 Baltimore, Maryland 21. Signature of Paneral Service License 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a and Enter the dissense or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, broken training. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel hyponatremic encephalopatha disease or condition resulting in deeth) Examiner Due to (or as a consequence ot): Acute Myscordial Inforction Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): 10 years CHF Box 68760 Physician/Medical the Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? should 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case reterred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Affer 5 Pending investigation 1 Netural efter death.

Director: After din by the fun 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be To the Hospital or Aftr within 24 hours after dr To the Funeral Direct completely filled in by 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-5alya 00051132 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ABREGO, DAFFINS LANE, DENTON, MD 21629

Registrar **DHMH 16 Ray 6/95**

State

31. Date filed (Month, Dey, Year)

AUG 8

2000

32 Registrar's Signature

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Juliet Allen Whaling 08 - 01 -2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Westley Home, Inc. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 11, 1909 5. Social Security Number 7. Ace (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1□M 2♥F Virginia 90 Director 215-34-0622 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Madical Examinar must be notified at 1 Yas 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21201 USA 12 West Hamilton St. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. Maling 1⊠ Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 28 No Specify: Specify p permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", nery Injury or other traumatic event, the Medical Example. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Juliet Allen Shannon Frederick Calhoun Whaling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 West Hamilton St., Baltimore, MD 21201 Bill R. O'Brien / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-4-00 Forest Hill, Maryland Deer Creek Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 5 Hours RESPIRATORY FAILURE Examiner Due to (or as a consequence of): Examine ASCVD sician end burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician s the buriel Physician/Medical Due to (or as a consequence of) 98 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. detached signed by t 1 Yea 2 No 3 Probably 4 Unknown Simile Deventia Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen : completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending P A hours after death. Funeral Director: After Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) To the F Within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) augarisone 40. D16619 August 2. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

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State

Registrar

BALTIMORE

AVE .

Registrar's Signature

W. ROGERS

2000

31. Date fited (Month, Day, Year)

AUG ?

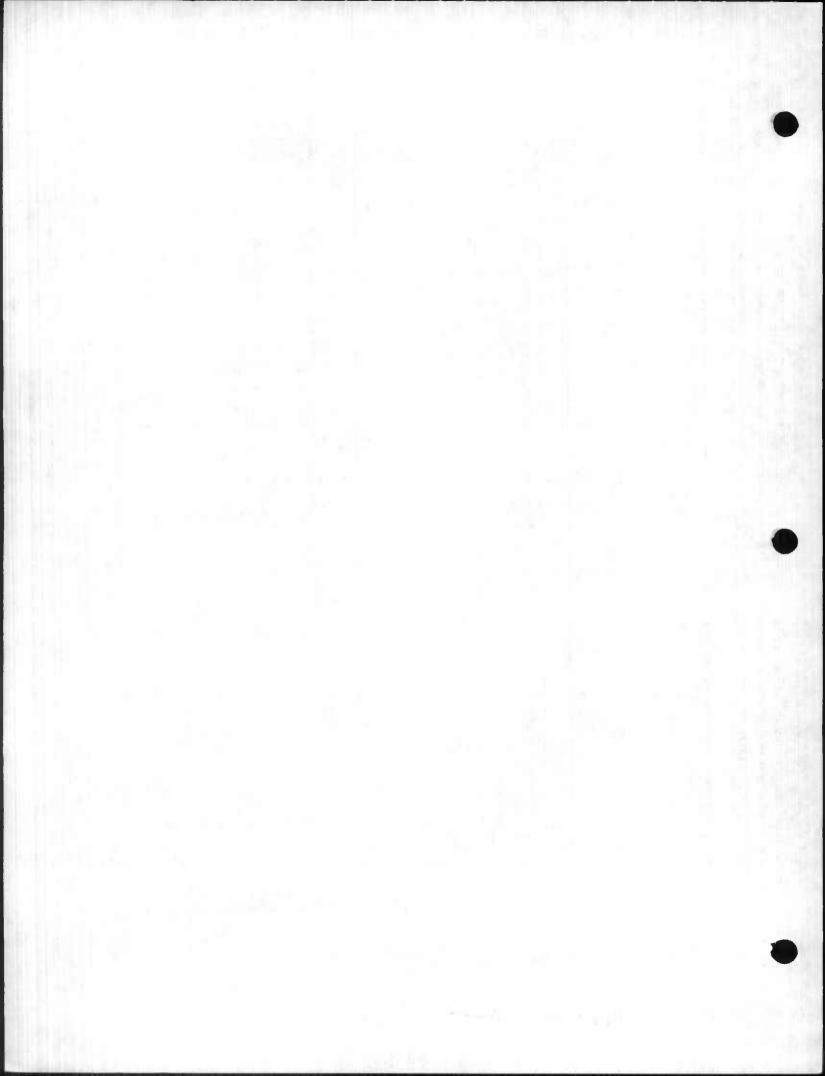
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State of Maryland / Department of Health and Mental Hygiene

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Maryland et show lited.at	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Washingte		ity, Town or I							10	0d. Inside City Limits
ar death with the Maryla Nerns 23s or 23s-1 sho ner must be notified at uneral Director	10e. Street and Number 1257 Lindsay Lane				Code 1742				Og. Citizen of V	What Coun	try?
020 020 020 020	11. Meritel Status 1 □ Never Merried 2⊠ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	U,S. 13	. Was Dece It Yes, spe	cify Cubi	ispenic Ori an, Mexicar Specify:	gin? (Spe i, Puerto	ecity Yes or No- Rican, etc.)		e - Americ ck, White,	etc.
1 21215-0020 ed within 72 hours a volume. Institution of the vor then "hetical Exam Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Giv	edent's Usu re kind of w DO NOT u Or Pr	ork done	duning mos			16b. Kind of Bu		lustry Processing
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Saltimore emit. Pages 1 : Nepartment of He important if Item ny Injury or oth nose.	20e. Method of Disposition 1 ☐ Buriei 2 ☑ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from Stete	Plece of Disp cemetery, cr ithsbu	emetory or	other plea		ug.1	Dete 5,2000	20c. Location - Smithsb	7,12	wn, Stete Maryland
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. p . p	Pert II. Other eignificant conditions co	ntributing to death but not re	sulting In the	underlying	cause giv	en in Pert I					the cause of death?
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of Vita Physician: this certific ral director,	25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	75D/O-1-1-1	2 D	Oth	er.		h (Check only o		on (Coonil	
yt all a	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time Injury	ot	28c. tnjur Wor			me 5 Resid			n
Division of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, s	street, tecto	y, office			28f. Location (5 City or Tow	itreet end Numt n, Stete)	ber or Rure	i Route Number,
within 24 hours a To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier 1 Certifying Phy cone) 2 Medical Exam	sician: To the best of my kr iner: On the basis of examin end menner steted.	nowledge, dea netion end/or i	investigation	n, In my o	pinion, dea	id place, ith occurr	and due to the d red at the time, d	euse(s) and me late and placa,	enner es si and due to	tated. the ceuse(s)
To the within To the com	29b. Signeture and title of certifier Michael (mlana	1 m			e number	6)		29d. Dete signe	5.60	
	30. Neme and address of person who co										
State Registrar	31. Dete tiled (Month, Dey, Year) AUG 1 5 200	32. Registrar's Sign	neture 4	vedic.	on W	-mp	US Pa	cel. 10	rgerit	wa	MO 21742



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** om 1000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore IAR land/ Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-16-1988 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Hours Min. 1□ M 201 F 12 DELAWARE 222-74-6436 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo DELAWARE SUSSEX FRANKFORD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 234 RD#3 BOX 244R 19945 U.S.A. Funeral death Nemal 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐ Yas 2X No f Yes, Give 1 Nevar Merried 2 Married "natural", or 1 ☐ Yes 2 🖾 No Specify: r Yes, Give Yaar or Datas: à WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry then Elementery/Secondery (0-12) College (1-4or 5+) 6 permit. Peges 1 and 2 should be filed w Department of Health and Mental Hygies Important: if item 27 is marked other to any Injury or other traumatic event, im-page. other 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Nema (First, Middla, Last) Peges 1 and 2 should be nent of Health and Mental ANTHONY DICKENS GLORIA J. DONOHUE 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) GLORIA J. WHITE/ MOTHER RT.1 BOX 461, DELMAR, DELAWARE. 19940 20b. Place of Disposition (Name of OLD Street BAPTIST CEMETERY 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 8-5-00 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Fecility MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 shock, or heart last se, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, List only one ceuse on each line. Approximate tnterval Between Onsat end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CEREBRAL EDEMA DAYS Examiner Physician/Medical Examiner MIDDLE CEREBRAL EFT ANTERIOR 36 HOURS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events INFARCTION ASTROCY TOMA 6 DAYS been signed by the attending physician should be detached for use as the buria HYPOTHALAMIC thet initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 2 No

Completed 8 Certification: To

25. Wes case referred to medical examiner? 27. Menner of Death

edical

1 Yas 2 No

5 Pending investigation

6 Could not be determined

Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Dete filed (Mog

29b. Signeture end title of continu

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, page 2 this certificate epitat or Attanding Physician: The hours after death.

nerat Director: After this certificate y filled in by the funeral director, pa within 24 hours a To the Funeral C completely filled To the Hospita

Baltimore, Maryland 21215-0020

100p

State Registrar ASST. PROFESSOR

29c. Licansa number

Injury at Work?

1 Yes 2 No

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Data signad (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1 ☐ Yes 2 ☐ No

2200

1 Yes

28d. Dascribe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

2000

South Greene St. VAIDYA

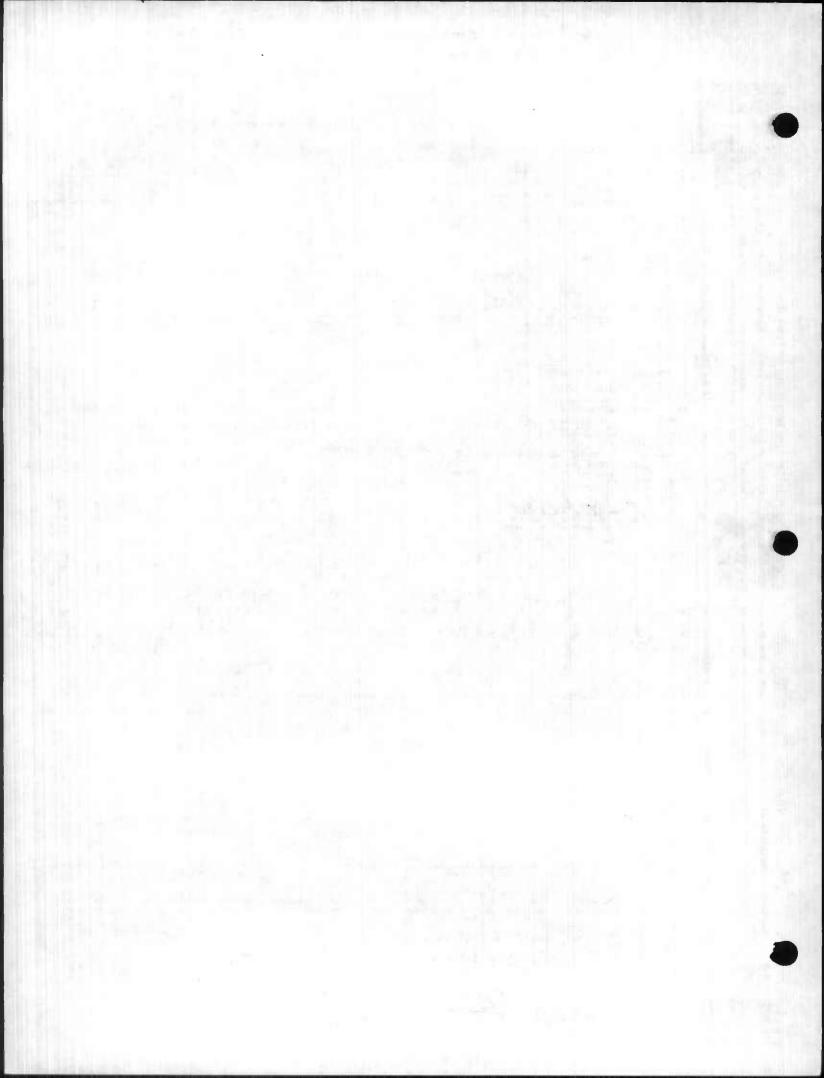
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2 ER/Outpatient 3 DOA

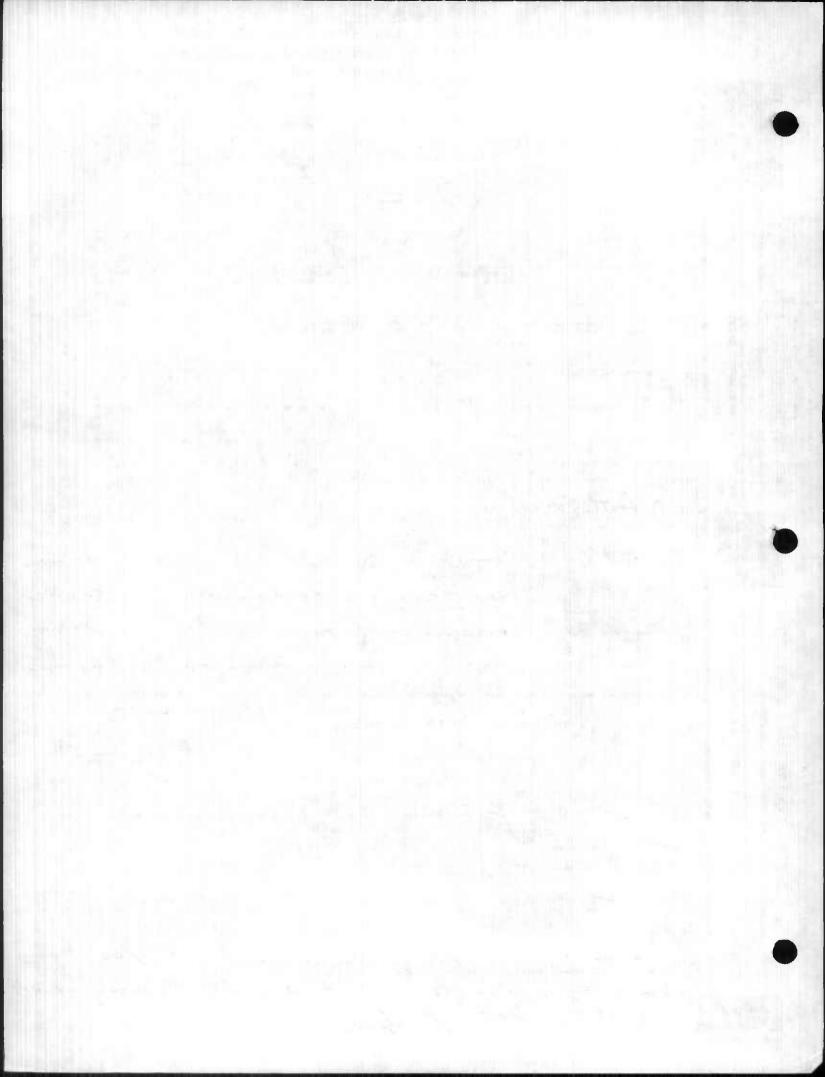
28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26977

					Ce	ertificate	e of i	Death			Reg. No.		
W		1. Decedent'a Name (First, Middle	, Last)							2. Date of De Month		Van	3. Time of Dea
Physicia		CHARLES	J		WAB	BECK				Aufu	ST 7	, Zuw	0 5 2 3
/Medic Examin		4a Facility Name (ff not institution		number)	71112	Bore	-	b. City, To	wn, or Loc	ation of Deet		County of De	
Examin	ier	PENINSULA REGI			משתי			CATI	CDUD	37			
70.47		5. Social Security Number	6. Sex	7. Age (in yrs.		If Under	1 Yeer	SAL J	LS BUR	8. Dete of Bio	reth.	WICO	
Funeral			1)∑) M 2□ F		Yrs.	Months	Deys	Hours	Min.	(Month, De	ey, Year)	9. D	inthplace (State or For Sountry) SACHUSETTS
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2 .		Usual Residence of Decedent 10a. State 10b. County		100 Cit	ty, Town or	Location							10d. tnside City Li
show	-	Tod. State		100. 011	ty, Town or	Location							1 ☐ Yes 2X
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with the Maryland a or 28a-f show Lea notified at	ie i	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	Country?
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ter deat	Funeral Director	11. Marital Stetus	12. Wes De	ecedent Ever in U	I,S. 13	3. Was Deced	ent of H	ispenic Ori	gin? (Spe	cify Yea or No	0- 1-		nerican Indien,
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nd 2 should be filed the and Mental Hyg		19e. informent's Neme/Relations	hip (Type, Print)		19b. Ma	iling Address	(Street	and Numbe	er or Rura	Route Numb	er, City or	Town, State,	, Zip Code)
2 = N L		SANDRA M. WABEC	K - WIFE		459	2 NUTT	ERS	CROSS	S RD	SALT	SBURY	, MD	21804
- 2 5 6		20a. Method of Disposition		20b. F	Place of Dis	position (Nam	e of			Date			or Town, State
mit. Pages 1 are partment of Hear portant: If Nem.		1 ☑ Burial 2 ☐ Cremation		m Stete		remetory or or			0.4	11/00			
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aw ras be	ple												completion of caus of death?
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ysician: The list certificate he director, page	O	25. Was case referred to medical						00 01	1.53				
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or Attend after death Director: / d in by the	tiffe	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 200. 110	ce of injury - At h	ome, farm,	street, fectory	office		2		(Street and		Rural Route Number
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pour sour fille	Je C	29a. Certifier 18 Certifyin	g Physician: To th	he best of my kno	owledge, de	ath occurred	at the tir	ne, date an	d place, a	and due to the	cause(s)	and manner	as stated.
To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical Certification:		Examiner: On the	basis of examina	ation end/or	investigation,	in my o	pinion, dea	th occurre	ed et the time	, date and	place, and d	ue to the cause(s)
thin the	M	29b. Signeture and title of certified				290	Licens	e number			29d. Date	signed (Mo	onth, Dey, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Month **Physician** 2000 6:25 P.M. August Jack Willett Young /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street end number) Examiner Clearview Nursing Home Hagerstown Washington H Undar 1 Year H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 25, 1916 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** 10 M 20 F Maryland 214-09-9822 84 Yrs. Director Usual Residence of Dacedent with the Maryland 10a. State 10c. City, Town or Location 10d. Insida City Limits 10b. County r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 X Yas 2 □ No Washington Smithsburg Md. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 2 Blue Mt. Estates U.S.A. Funeral death 14. Raca - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itse any injury or other traumatic evant, the Medical Essential DDS. 1 N Yes 2 No
If Yes, Give
Yeer or Dates: 41-46 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Mary F. Willett John H. Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 316 Overbrook Rd. Hagerstown, Md. 21742 Mary Jane Shipley (Daughter) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Aug. 11 20c. Location - City or Town, State 1 Degree 2 Cremation 3 Ramov I m State Donation 5 Other (Specify) 2000 Hagerstown. Md. Rest Haven Cemetery 21. Signature of Funeral Servica Lic 22. Name and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home ennis Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) Avleance 5 days Acute Bronchopneumonia Examiner Due to (or es a consequence of): Physician/Medical Examiner Carcinoma of Luna 1 year The law requires that the death certificete be axecuted ed by the ettending physician end deteched for use as the bunal-trans Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Dua to (or as a consequence of): 88 23b. Dfd tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part If. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Pres 2 No 3 Probably 4 Unknown Peripheral Vascular Disease þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Above the knee amputation of right leg page 2 s is certificata h 1 Tes 2 NO 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 200 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation in 24 hours effer describe the Funeral Director: Afr 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. edical completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

Dr

32. Registrar's Signature

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

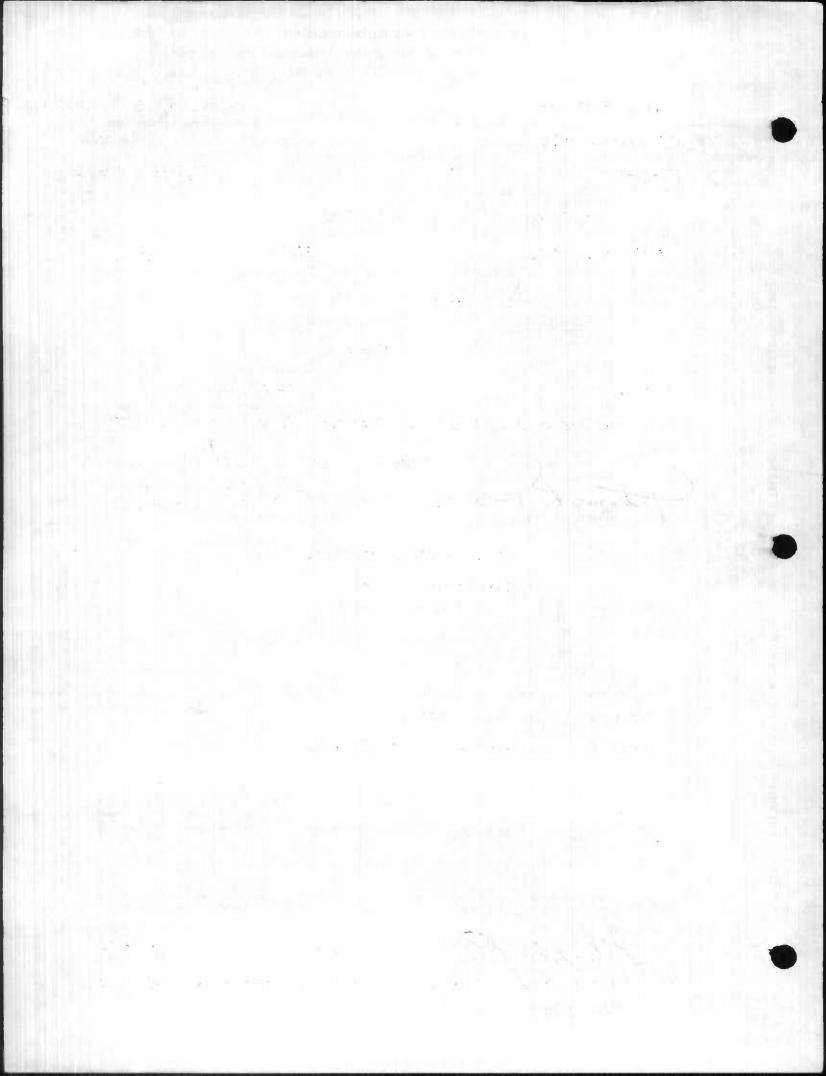
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31. Data filed (Manth Cay Year) 2000

Edson B. Moo'dy

1190 Mt. Aetna Road, Hagerstown, Md oocker.

21740

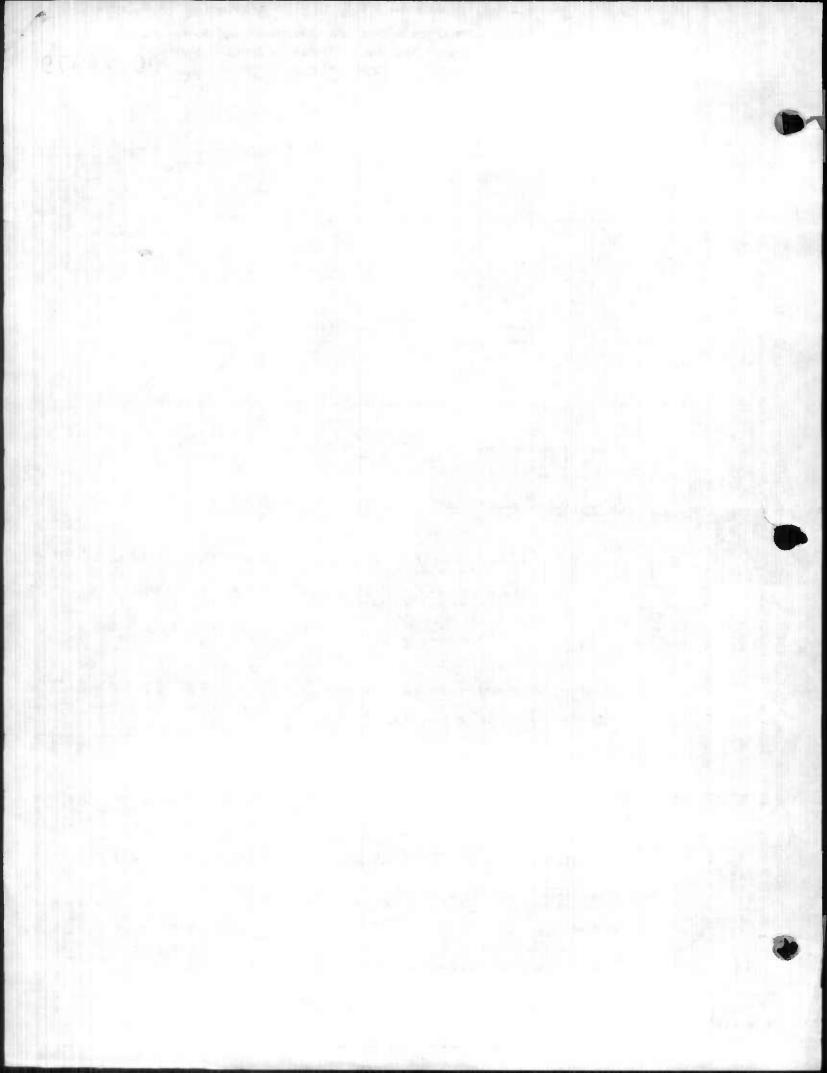


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month **Physician** Nira 22, 2000 Awad 2115 Aug. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Anne Arundel General Annapolis Anne Arundel 5. Social Security Number if Under 1 Year 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min 1□ M 3€3€ 35 Yrs. Director 219-78-4900 09-21-64 MD Usual Residence of Deceder the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f ahow Exerciper must be notified at 1 Yes XXNo Director MD Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 646 Greenbryer Funeral Lane 21401 death 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 natural', or 1 Yes 2 No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced ntal Hygiene. ed other than "natura s event, tre Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade NA Care Provider outside home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) s 1 and 2 should be fill Health and Mental H tam 27 is marked oth other traumatic evan Be Barbara Alhajji Hassan Spriggs 19e. Informant's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 1 4 0 1 itam 27 la Barbara Awad 646 Greenbryer Lane Annapolis, Maryland 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Date permit. Pages 1 Department of H Important: If its any injury or ott page. 1 € Buriel 2 Cremetion 3 Removal from Stete King Mem. Pk. Cem. 08-26-2000 Randallstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue W a dup ans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical YOCARDIA. Examiner Due to (or es e conseque Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events pue Due to (or as a consequence of) 68760, Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) the Box 980 P.O. e pe Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tota 2 No 3 Probebly 4 Unknown 2 TOMEGOLOVIRUS þ Records. 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law page 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 15 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28e. Dete of Injury (Month, Dey Year) 28b. Time of 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred After Division Attending re the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1-2 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 📹 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) and manner as steted. 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated. (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of deeth (ttem 23a) (Type, Print) 205, RIDGELY AVENUE AMMAPOLIS, MD 21401 REEDMAN MICHAEL 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 25

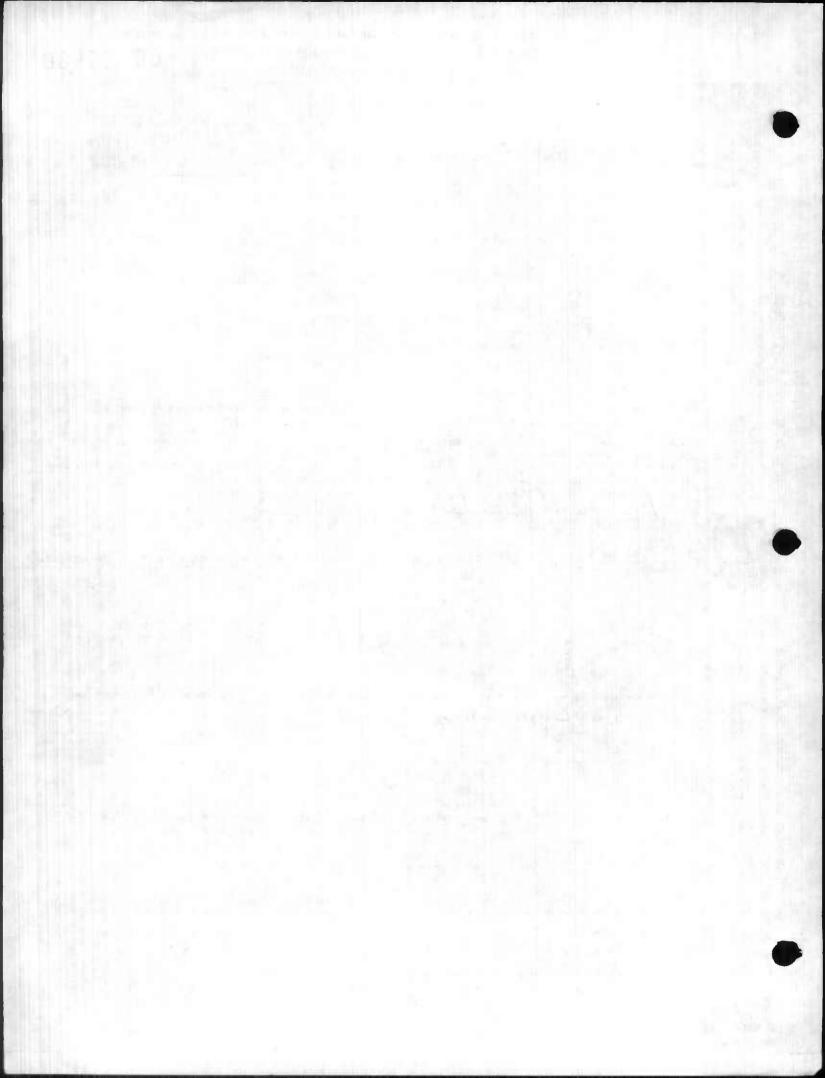
DHMH 16 Rev 6/95

Registrar



4.	Amended	ite	m #8 per FH G786 8-25	-OOWJJ	arylan				lealth and l		Reg. No.		980
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	23a or		404 Torne	r Road					21221			USA	
1	urs after death al', or items 23	by Funeral	11. Meritel Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 F If Yes, Give Yeer or Detas:		,S. 13.		edent of F becify Cub	dispanic Origin? (Sen, Mexican, Puarl Specify:	pecify Yes or N to Rican, etc.)	o- 14. Rac Bled Specify	e - American Ind ck, White, etc. : White	
7 2	d within 72 hor plene. r than "neture gre Medicel I	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5	5+)	(Give	DO NOT	use retire	during most of wor			usiness/Induatry Of MAryl	and
AP	Hed by by by by by by by by by by by by by	ro Be Co	12th 17. Fathar's Nema (First, Middle, Las. Everett	B Wilson		1.0001	Gatt		18. Mother's Ner		e, Maiden Sumen		
	2 should end Men is marke sumatic		19e. Informant's Neme/Reletionship			19b. Mail	ing Addre	ss (Street	and Number or Re	ural Routa Num	ber, City or Town,	Stete, Zip Code,	
Je.	of Heelth of Heelth f Nam 27 r other tr		Joseph Alford / 20e. Method of Disposition 1 Burial 2 Cramation 3 [Ramovel from Stete	0	Plece of Disposematery, cre	osition (Nemetory o	leme of r other ple	ce)	Baltimo	20c. Location	City or Town, Si	tate
Baltim	Department Department Important: I any Injury o		4 Donetion 5 Other (Speci	nsee	11		2. Name	and Addra	iss of Facility	3/2000 Home o	Baltin ofEssex		
O P	Physician /Medical		23a. Partt. Enter the disease, or conshools, or heart failure. List only				300 hter lhe m	MACO	ng, such es cardia	1timore c or respiratory	e Md. 212 arrest,		oximete val Between it end Deeth
	Examiner	70	disease or condition resulting in death)	A. PRO		BCE or es e conse	equence o	f): .	cordual	Info	archon	mi	nutes
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Κ _{b.}	Due to (c	peu or es a conse	-						srac
Box 68760,	ata be hysicia the bur	dical	Cause (Disease or Injury that initiated events resulting in death) Last	d	Due to (o	or as a conse	quence of	n):					
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s, P.O	v requires that the death cert been signed by the attendin should be deteched for use	by Physician/Me		ympho			on conyma	y cause g	voir art i.			3 ☐ Probably	
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<u> </u>	- 0 -	To Be	25. Was case referred to medical examiner? 12 Yes 2 No	Hospital:	ent 23	ER/Outpatie	ent 3 🗆 (DOA Ott	26. Plece of De her: 4 Nursing I		rone) sidence 6 □Otr	ner (Specify)	
lon of	After thi funerei	ation: T	27. Manner of Death 1 Matural 5 Pending 2 Accident Invastigation	28a. Dete of Inju (Month, De		28b. Time Injury		28c. Inju Wo		4	e how injury occur		
Divis	To the Hospital or Atlanding Physikin is About a little death. To the Funeral Director: After this completely filled in by the funeral	Medical Certification:	3 ☐ Suicide 6 ☐ Could not to determined	building, et	c. (Specil	(y) 				City or T	(Street and Numl own, Stete)	_	e Number,
	n 24 hou n 24 hou ne Funer pletely fil	edicai		nysician: To the best of miner: On the basis of and menner ste	exemine								suse(s)
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	0		30. Name end address of person who GEORGE KARKAR,	completed cause of d	leath (Item	77 Par	Print) _ NT L	BOULE	VARD,	BALTIM	DORE M	D 212	24
+	Stat Registra	_	31. Dete filed (Month, Dey, Year)	00 32. Hegistr	at - Signic	eture /5	py	port	3		1		

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 23, 2000 Marilynn Joyce Alley 8:14 PM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1□M 2⊠F Yrs. Director 217-34-5579 Maryland Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show the Medical Examiner must be notified at t ☐ Yes 2 No Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8029 Shore Road 21219 U.S.A. Funeral 12. Was Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ltems. 11. Maritai Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify. White Specify: p 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Dispatcher permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked ofth any injury or other treumatic event BABS. 17. Father's Neme (First, Middle, Last) Martha Hands James Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Norman W. Alley / husband 8029 Shore Road, Baltimore, Maryland 21219 20b. Piaca of Disposition (Neme of camatery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/26/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Entar tha disaase, or com-shock, or heart tailure. List only Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician /Medical Immediate Causa (Final holangiocarcinomA 6 months diseasa or condition resulting in death) Examiner Due to (or as a consequence ot) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): that the death certificate be axecu 68760 Physician/Medical Dua to (or as a consequence of): Box (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? P.O. 1 Ses 2 No 3 Probably 4 Unknown by Division of Vital Records, The law requires 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yes 2 No Physician: 25. Was case reterred to medical axeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yes 2 100 this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Aftar Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death Director: // 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title uno 025205 and address of person who completed cause of death (Item 23a) (Type, Print) N. Charle St. Balto md 2,205

DHMH 16 Rev 6/95

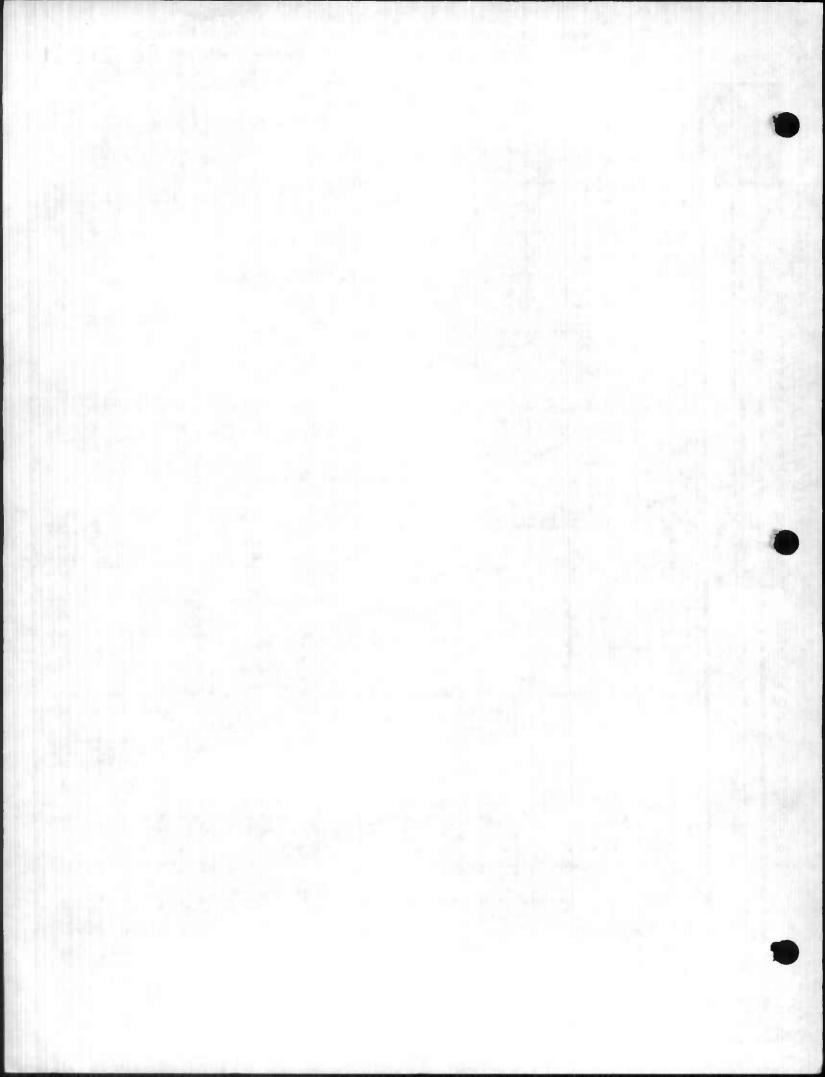
Registrar

2000

31. Date filed (Month, Day, Year)

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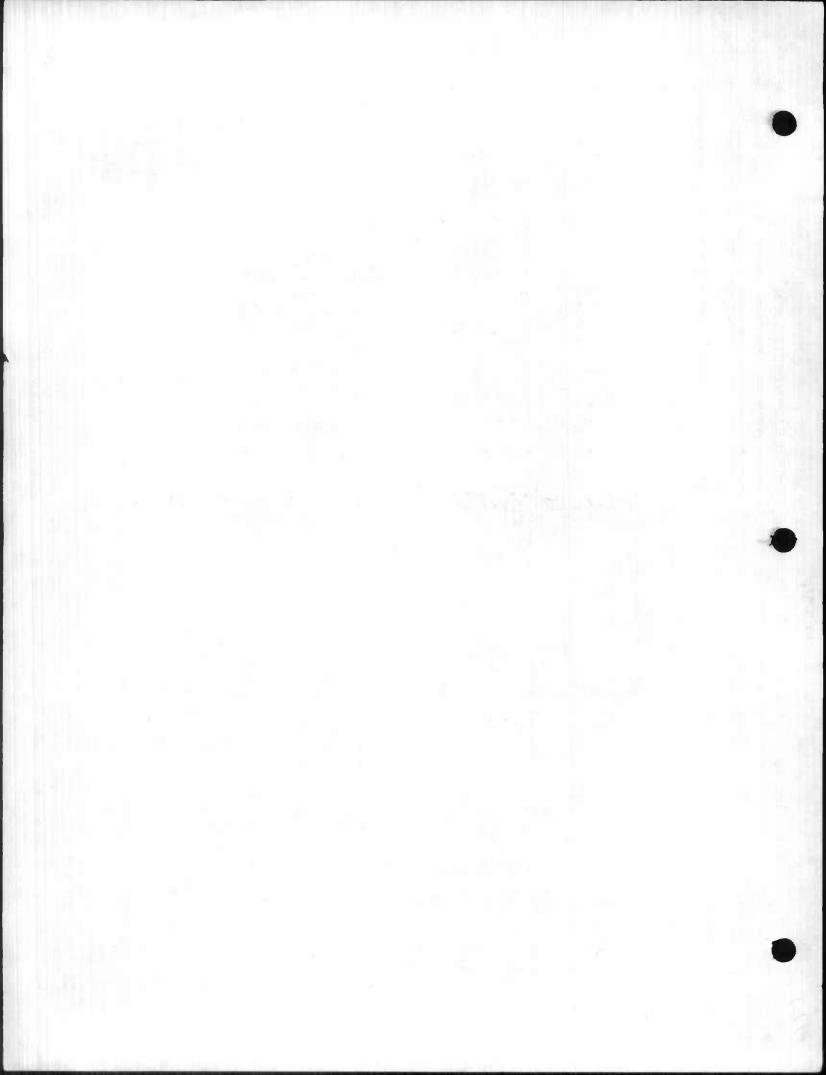
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 00 2000

	1. Decede	nt's Neme (First,	Middle, La	ast)							2	. Date of De			W	3. Time	of Death
cian	Do	nald Arm	stron	ng							1	Month August	Day 22	2	Year 2000	3:3	0 pm
dical niner	4a Fecility	Name (If not ins	titution, giv	ve street a	and number)				4b. City, Town	or Loca	tion of Deat	h 4c. (County	of Death		
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		ecurity Number	6. 9	Sex	7. A		last birthday		or 1 Year Days	If Under 24		Date of Bir	rth		9. Birthpl	ace (Stat	te or Foreic
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** WELLMAN Brooks RANDOLPN August 23 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NUTSING HOME LUTHERN LOCHERN BALLINURG If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days 10 M 20 F 216 54 3736 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits HEYES 2 No BALTINUIE Funeral Director Marylows ital Hygiene id other than "natural", or items 23s or 28s-f event, the Medical Examiner must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #3105 2503 UIOLET AVE 2/215 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 100 Specify by 3 ☐ Widowed ◆ Divorced Black Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SE y Employed Elementery/Secondery (0-12) College (1-4or 5+) ARDENTER 9th grade 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Brooks TRAVIS HARRY 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pript) Ħ TimoTHY Brooks 2007 WHEELER AUG BAHHNOR, Marylono Nam 27 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date important: if is any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility CNATH DW HAKKEN FN. 21. Signature of Funeral Service Licensee REISTERS POUR ROAD Harrin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Being Approximate Intervat Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical leavs **Examiner** Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the buriel-tran Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No 1 Yes 2 No funeral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 1 | Medical Certification: To 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 of Vital Records, this certificate hes Division Affer s after des. To the Hospital within 24 hours a To the Funeral D

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Pages 1 and 2 s ment of Health an

Saltimore,

Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, DAUG G 2 5 2000

29b. Signature and title of certifier

HAROLD

29e. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 25 32. Redistrer's Signature

57

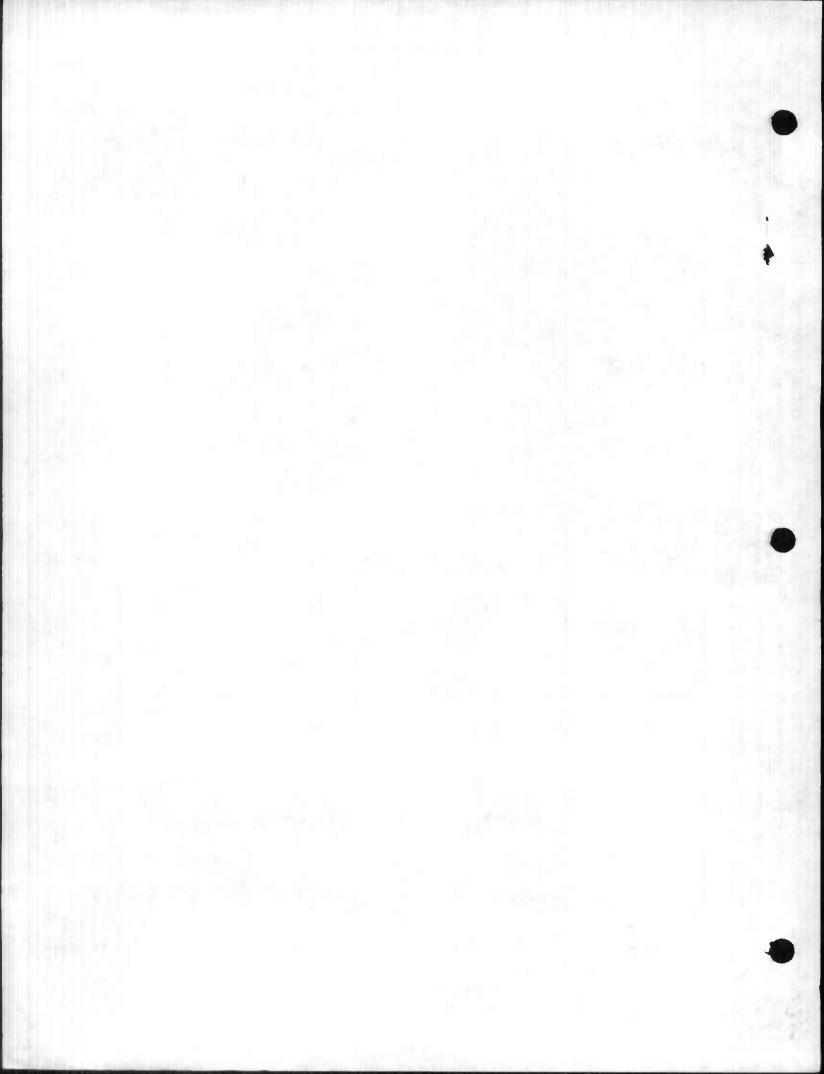
1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

Main

29c. License number

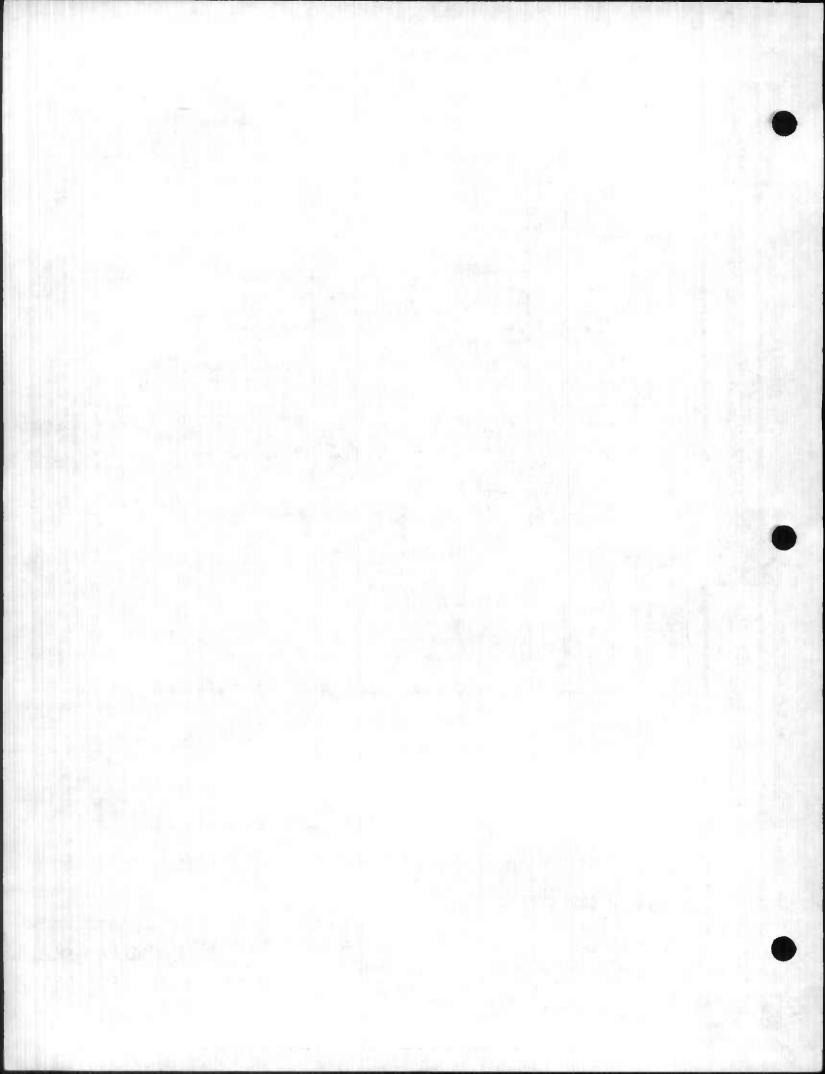
29d. Date signed (Month, Dey, Year)

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/Medical Examiner	4a Facility Neme (If not institution, give				4b. City, Town, or			
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month BLACKWELL ROYSTON RICHARD AUGUST 6:20 PH 15 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Baltimore 1ATI920H Randallstown NORTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months Days Hours MM 20F 84 220-18-4351 Yrs Aug. 26, 1915 Va. Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits Baltimore Woodlawn 1 Yes 2 No 10f. Zip Code 21 207 10e. Street and Number 10g. Citizen of What Country? 6829 Lenbern Road USA 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 √Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier US Postal Service 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Henry A. Blackwell Sr. Ruby Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) wife Janet D. Blackwell 6829 Lenbern Road Woodlawn Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Dether (Specify) Entombment Arbutus Memorial Park Aug. 26 Baltimore, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service License 2501 Gwynns Falls PKWY Baltimore, Md. 21216 butter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Causa (Final disease or condition resulting in death) INTRACRANIAL HEMORRHAGE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events rasulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown PULMONARY EMBOL 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? URINARY TRACT INFECTION 1 □ Yes 2 Ho 1 ☐ Yes 2 ☐ 100 26. Place of Deeth (Check only one) Hospitel: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stala

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Director

Funeral

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Completed

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Funeral

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If then 27 is marked other any Injury or other trauments of the

Baltimore, Maryland 21215-0020

attending physicien and for use es the burial-transit as been signed by 2 should be detac has

Box 68760,

P.O.

Records,

Division of Vital

Examiner edical Certification: To After this

Physician/Medical þ Completed Be

Hospital or Attending 24 hours after death. eral Director: / To the Hospital of Within 24 hours at To the Funeral D completely filled it

25. Was case referred to medical 1 Yes 200 No

3 Suicide

29a, Certifier

4 Homicide

27. Manner of Death 1 Meturat 5 Pending investigation 2 Accident

28a. Date of Injury (Month, Day Year) 6 Could not be determined

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier

MD

D 54352

29c. License number

29d. Data signed (Month, Day, Year) AUGUST 21. 2000

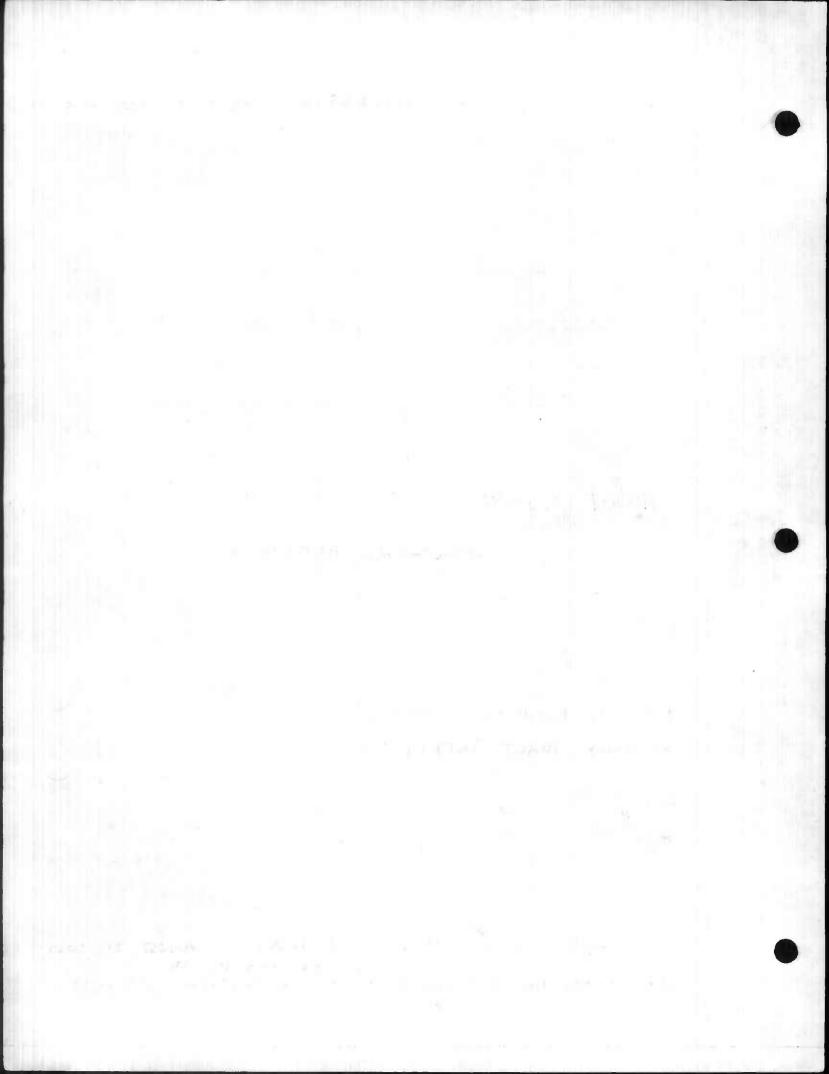
MD 21133

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) MiRCEA TODOR, NORTHWEST HOSPITAL SHOT OLD COURT ROAD RANDAUSTOWN

31. Date filed (Month, Day, Year)

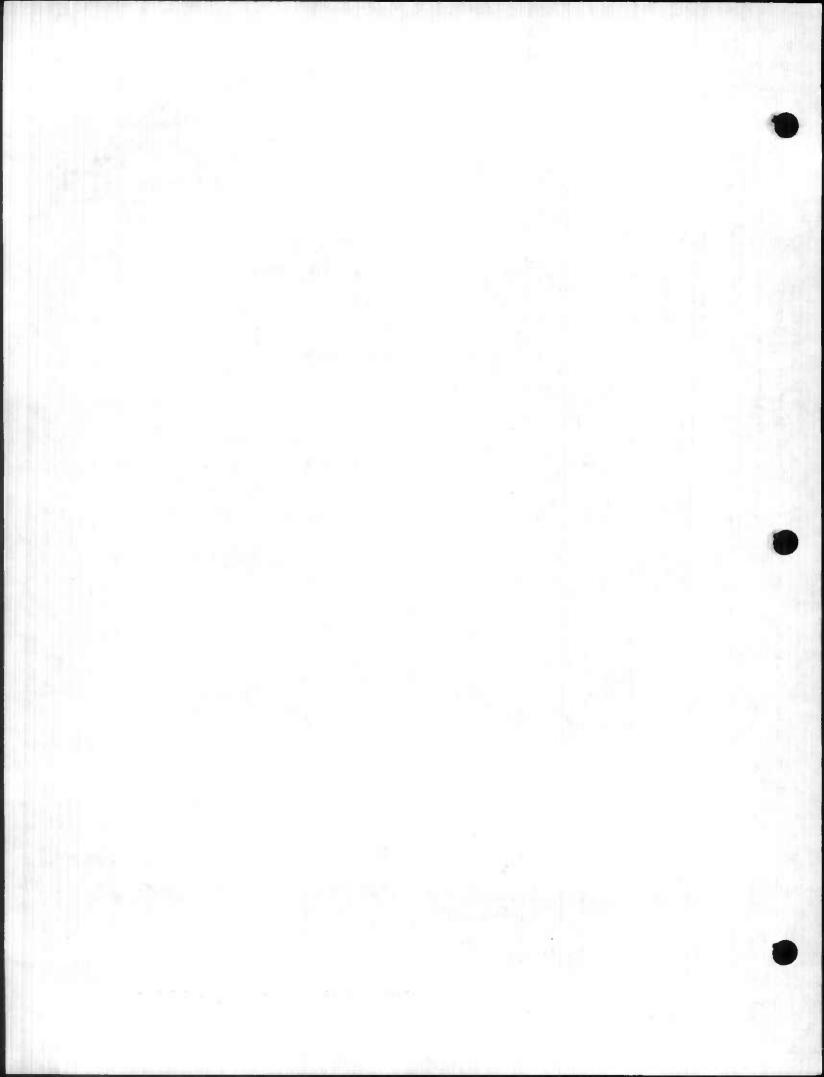
32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 26986

N		Certificate of Death	Reg. No.		
Dhuciaian	Decedent's Name (First, Middle, Last)		2. Data of Death	3. Tima of Death	
Physician /Medical	THOMAS LEE BROWN ,	<u> </u>	AUGUST 19, 200	00 02:58 A.M.	
Examiner	4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Li			
	SINAI HOSPITAL	BALTIMO Was last hirthday) If Under 1 Year If Under 24 Hrs.			
Funeral Director	5. Social Security Number 217-80-1217 Usual Residence of Decedent	yrs. last birthday) Yrs. f Under 1 Year If Under 24 Hrs. Months Deys Hours Min. Min.	8. Date of Birth (Month, Dey, Year) 9. Bir C	rthplace (State or Foreign Country)	
th with the Maryland 23a or 25a-f show ust be notified at all Director		City, Town or Location		10d. Inside City Limita	
	MD BALTIMORE RA	ANDALLSTOWN		1 Yas 2 No	
	10e. Street and Number	10f. Zip Code	10g. Citizen of Whet C	country?	
	6 OX YOKE COURT	21133	us	A	
iner must siner must Funeral	11. Meritel Stetus 12. Wes Decedant Ever in Armed Forces?	n U,S. 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Maxican, Puerto	pecify Yas or No- Rican, etc.) 14. Race - Am Black, Whi		
D	1 Nevar Married 2 Merrled 1 Yes 2 No If Yes, Give Year or Detes:	1 Ves 2 No Specity:	Specific	ACK	
dical	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business	s/Industry	
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vent, th	12 TH GRADE 3 YRS 17. Fether's Name (First, Middle, Lest)	FINANCIAL ADVISOR	HOSPITAL e (First, Middle, Maiden Surneme)		
arked other than "naturation are event, the Medical. To Be Completed	THOMAS LEE BROWN, JR.		ELLA EDMOND		
T Mark	19e. Informent's Neme/Reletionship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
27 ls ma 7 traums	ELLA BROWN MOTHER				
sernit. Pages 1 and 2 should by Supplication of blessift and Menta reportant: If lean 27 is newbed any Injury or other traumetic even ADCs.	20a. Methed of Disposition 20	b. Plece of Disposition (Nema of cemetery, cremetory or other plece)	Date 20c. Location - City o	r Town, Stata	
	1 Burlal 2 Cremetion 3 Ramoval from Steta 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 8.24.00 GLEN BURNIE, MO				
	21. Signature of Funeral Sarvice Licensaa VAUGHN C. GREENE FUNERAL SERVICE				
8558	Vaugh C. GREENE PUNELLE SALTO. MD. 21229				
Physician	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest. Approximate				
	Onset and Death				
ledical aminer	Immediate Cause (Finel disease or condition resulting in death) a. Due to (or es e consequence of):				
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physician and as the burial-transit edical Examiner	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c.				
physician s the buria	cause. Enter Underfying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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ed for	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death			te to the cause of death?	
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aw requir			24a. Was an eutopsy performed?	. Wera autopsy findings available prior to completion of cause	
				completion of cause of deeth?	
			Yes 2□No	Yes 2 No	
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deat ctor: y the	3 Suicide 6 Could not be	At home, ferm, street, factory, office	28f. Location (Street and Number or I	Rurel Route Number,	
din b	Aomicide Getermined Building, etc. (Spi	ecity) Residence	SYOZ (rode ~1)	Are 21244	
To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page. Medical Certification: To Be Com	29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.				
	(Check only 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.				
Tota	29b. Signalities and tible of certifier	29c. Licanse number			
	1/ Octoberno	O.C.M.E.	AUGUST 1	19,2000	
D	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)			
10	J-CARLON LOCKED MI	111 Penn Street, Baltim	ore Maryland 212	01	
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Si	ignatura			
Registrar	AUG 2 5 2000	9 sparks			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

26987 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bembry Shirlene AUgust 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number, 4c. County of Death Examiner County General Hospital Columbia Howard HOWard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA 6. Sex 5. Social Security Number **Funeral** 10 M 20 F 166-44. 7486 48 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show the Medical Examiner rount be notified at 1 Yes 2 No Funeral Director MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4350 COLUMBIA ROAD 21042 USA nems ; 13. Was Decedent of Hispenic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Meritel Status filed within 72 hours after 1 Yes 2 No
It Yes, Give
Yeer or Dates: 1 Never Married 2 Married 8 21215-0020 1 Yes 2 No Specify BLACK by 3 Widowed 4 Divorced nature Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) 8 YRS Elementary/Secondary (0-12) MANAGER UNIVERSITY OF MO 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland ie marked of Pages 1 and 2 should be JOHN ETHEREDGE NELLIE TRIBBLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. totormant's Name/Relationship (Type, Print) if item 27 is 4350 COLUMBIA RD. COLUMBIA, MO. 21042 HUSBAND BEMBRY JAMES 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ò 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If 18.25.00 RANDALLSTOWN. Injury 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility eny in VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE, BALTO. MO. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or limit tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical BREAST CANCER YEARS Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence ot) Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Dunknown RENAL FAILURE Records, þ 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed SINUSITIS page 1 Yes 1 ☐ Yes 2 ☐ No PNEUMONIA of Vital Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Division or Attending 1 Matural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1 Certifying Phystclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely within 2 ş 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and tale of portifie To ASYMD D39629 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 16 Ray 6/95

31. Date tiled (Month, Day, Year) AUG 2 5 2000

ALGXANDER SY MD

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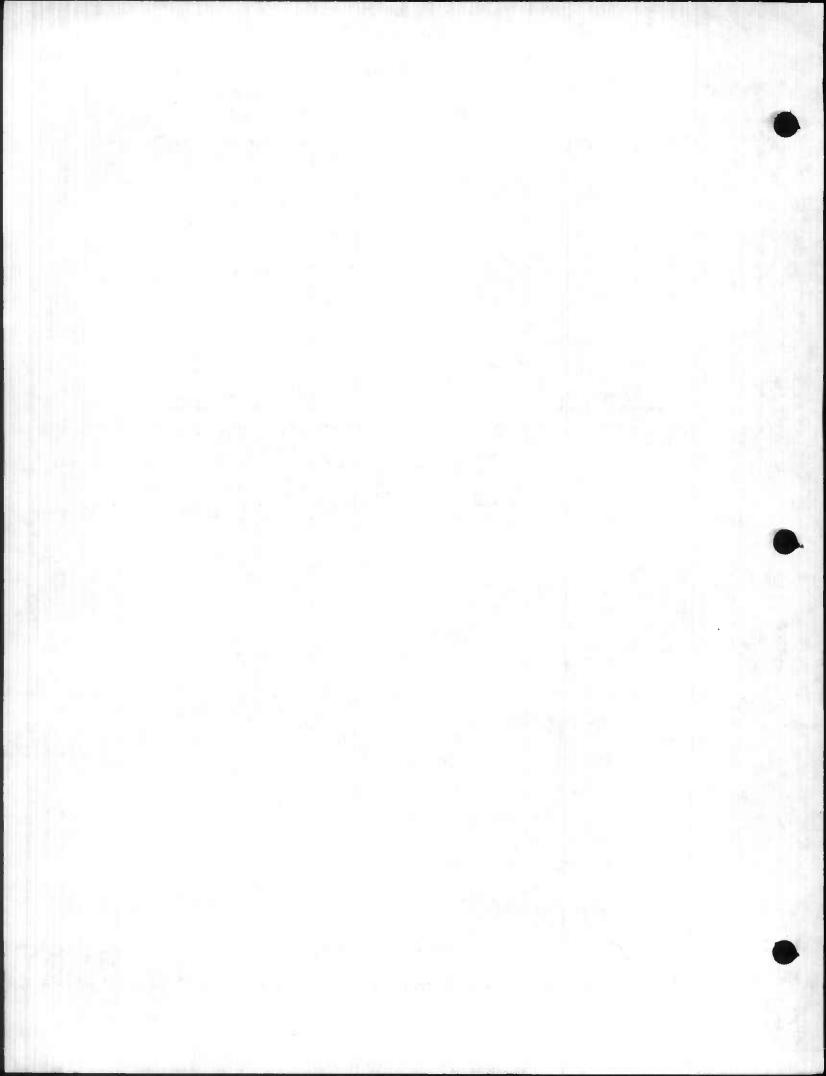
32. Registrer's Signature works

LITTLE

PATUYENT PKWY.

COLUMBIA

MD 21044



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\int\)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Debbie Lynn Boggs 850 pm 23 2000 August /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rosedale Center Baltimore Franklin Square Hospital 8. Dete of Birth (Month, Dey, Year) If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stele or Foreign Country) **Funeral** 1□M 20 F Months Deys Hours Yrs. 215-78-1736 43 Aug 1,1957 Director MD. Usuet Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yes 2 No Completed by Funeral Director Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8020 Wynbrooke Rd. 21224 items 23a USA 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 275No If Yes, Giva I Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien Bleck, White, etc. other traumatic event, the Medical Examiner 1 Never Merried 2 Married 1 Yes 25 No Specify: Specify: White b 3 Widowed 4 Divorced "natural" 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if New 27 is marked other than "nationy or other traumatic event, the Medical page. 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Cottege (1-4or 5+) Never worked 12 yrs Never worked Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Milfred Ray Boggs Alma Elaine Diddlemeyer 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 2 4 19e. Informent's Name/Reletionship (Type, Print) Darlene Hundt sister 7751 East Baltimore Street, Baltimore, Md. Baltimore, 20b. Plece of Disposition (Name of cematery, cremetory or other plece) Aug 24 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 4 □ Donetion 5 □ Other (Specify) Metro Crematory 2000 Catonsville, Md. Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, MD.21222 Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or haart failura. List only one ceuse on each lina. Approximete Intervat Between Onsat and Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) · Brainstem Herniation Days Examiner Due to (or es a consequence of) Examiner Shunt Remova 7 Days the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, attending physiclan Maningitis

Due to (or as a consequence of): Septic Physician/Medical 20 Days 43 years . Congenital Hydroce phalus P.O. been signed by the should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 700 3 Probably 4 Unknown of Vitai Records, py 24b. Were autopsy findings available prior to completion of causa of deeth? Be Completed 24e. Was en autopsy periormed? After this certificate has 2000 1 Tyas 2 No 1 Yas papital or Attending Physician: Theoris effer death.
Inversity Director: After this certificate by filled in by the funeral director, pa 25. Wes cese referred to medicat axaminer? 26. Place of Death (Check only one) Hospitel: 1 Department 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Death 1 Deaturet 28d. Describe how injury occurred 28c. tnjury at Work? Division 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Mospital within 24 hours e To the Funerel D Decrifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier completely (Check only one) 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) August 23, 2000 047390 かつ 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) DR Ivan Borrello 9000 Franklin Square Drive Baltimore Mary land 21237 31. Data filed (Month, Dey, Year) 32. Registrer's Signetura State AUG 2 5 2000 Jener

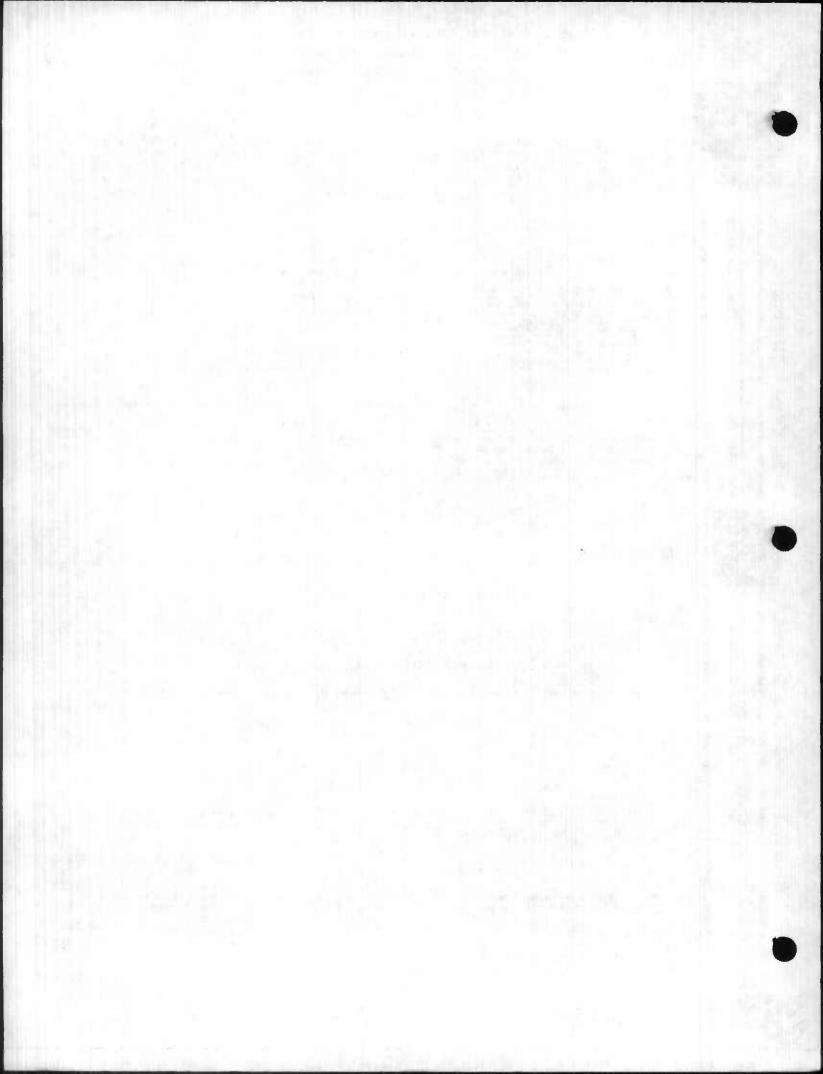
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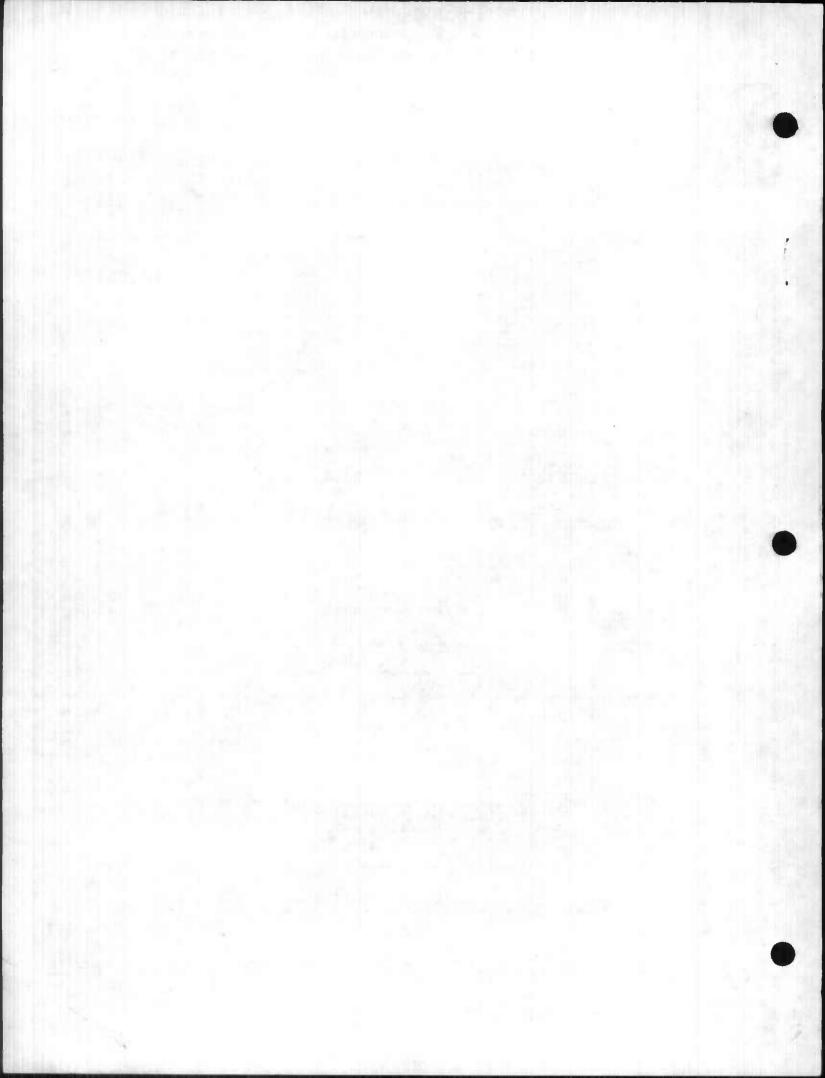
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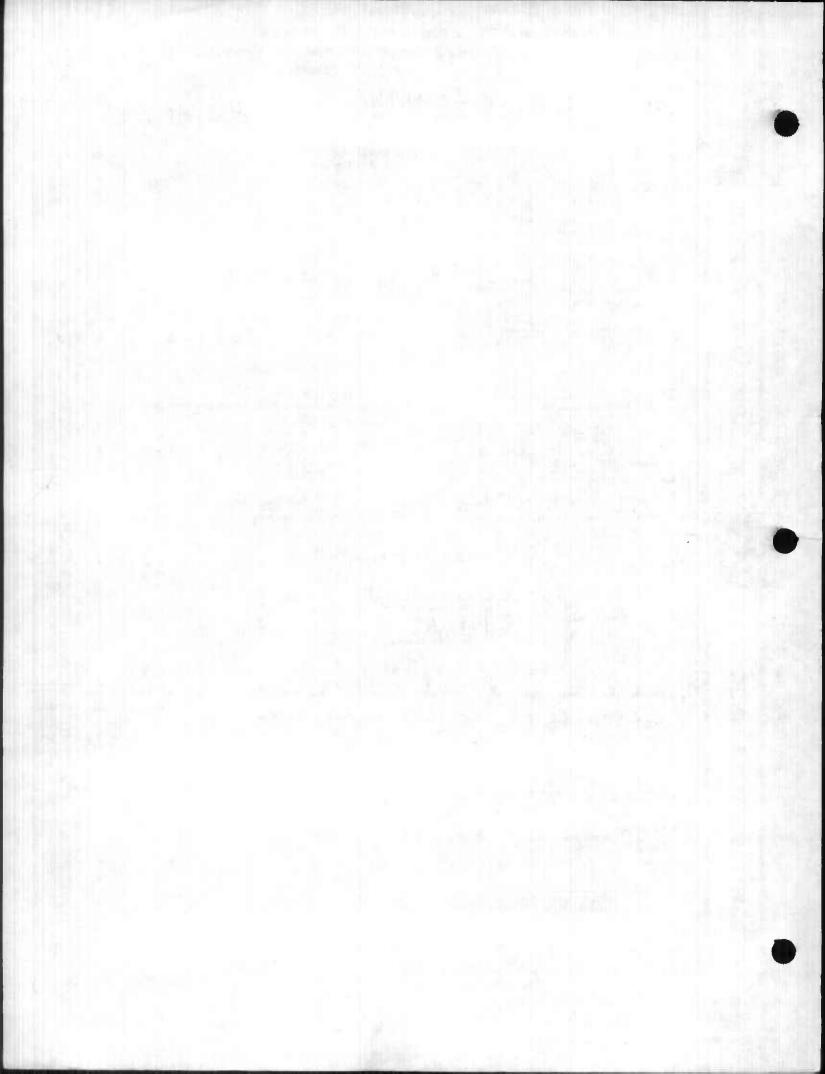
State of Maryland / Department of Health and Mental Hygiene 0 26989

		Certificate of Death	Reg. No.	309
D1 -1-1	Decedent's Neme (First, Middle, Last)		2 Date of Death 3.1	Time of Death
Physician /Medical	THOMAS HENRY CARTER,		August 19, 2000 7	20pm
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Local	ation Deeth 4c. County of Deeth	
	Maryland General Hospi	tal Baltmire	City W/12	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. le	est birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Birthplace (Country)	(State or Fore
Director	214 50 1171 EM 20F 57	Yrs. World's Days From Min.	nou 29,1942 Mary	
9	Usuel Residence of Decedent			
Page 1	10a. Stete 10b. County 10c. City,	, Town or Location		nside City Lin
28a-f shownout of the country of the	Mary mo	BAIHMOVE		₩es 2□
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rier dearn with the Market is them 23a or 28a-1 a virtue market be notified. Funeral Director	11. Maritel Status 12. Wes Decedent Ever in U.S Armed Forces?	 Wes Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R 	cify Yes or No- lican, etc.) 14. Race · American for Black, White, etc.	dien,
a 0 5	Never Married 2 Merried 1 Yes 170 H Yes, Give	1 ☐ Yes 2 ☐ No Specify:	Specify:	
	3 Widowed 4 Divorced Year or Detes:	12 100 22 10 0000.	sporting ys lack	_
ygiene. or than "natural", rt, the Wedges Ex	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry	1
a du	Elementary/Secondary (0-12) College (1-4or 5+)	0	nursing Ho	ms
at Hygiene.	124 gizde	TURE		
d oth	17. Father's Neme (First, Middle, Last)		(First, Middle, Maiden Sumeme)	
Ment Ment	THOMAS H. CARTER, SR.	Addie.		
Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M	19a, Informant's Neme/Relationship, (Type, Print)	19b. Mailing Address (Street and Number or Rural		
Pr tr	SAdie Prince Pount	1137 N. Com // ton for	VE BALTIMOIE, MA	vy low
of Health item 27 r other tr	Total monitor of Diopholysis	ace of Disposition (Name of emetery, cremetory or other place)	Date 20c. Location - City or Town, S	State
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: 본론을	21. Signeture of Funerel Service Licensee	22 Name and Address of Facility	ATHAN - HAMEN TURE	ast Hon
Department Department Important: any injury	21. Signistrate of Full and Service desirates	5240 RUSTERStown	LI ADO	7,170
	Esliay Haun	BAHAMER, MARYLA	onp 2/2/1	
	23e. Pert. Enter the disease, or complications that caused the deeth, shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dying, such as cerdiac or	respiretory arrest, App	roximate rvai Between
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/Medical	Immediate Cause (Final disease or condition	URREST		
Examiner	resulting in deeth)	as a consequence of):		
ě	End Stan	re Kenal Disease	>	
icien and burial-transit	Sequentially list conditions Due to for	es a consequence of):		
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or Injury	25/m		
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	resulting in death) Last	as a consequence ory.		
nding Jsa a	d			
the attendin				
gned by the attending be detached for use a by Physician/M	Part II. Other algnificant conditions contributing to deeth but not result	Iting in the underlying cause given in Part f.	23b. Did tobacco use contributs to the	./
ed by detac	Dilateral Above the K	nee Amoutation	1 Yes 2 No 3 Probably	4 Unk
been signed the should be detected by Pieter b			24a, Was an autopsy 24b, Wera a	utoney finding
sate has been sign page 2 should be			performed? available	le prior lo tion of ceuse
has b			of destr	17
Page C			1 ☐ Yes 2 ☐ No 1 ☐ Yes	s 2 No
certificate rector. pag	25. Wes case referred to medical	26. Piace of Death	(Check only one)	
this certificate has ral director. page 2	examiner? 1 Yes 2 No Hospitel: 1 Impatient 2 E	ER/Outpetient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)	
5 8	27. Manney of Death 28e. Dete of Injury	28b. Time of 28c. Injury at 2	8d. Describe how injury occurred	
to tun	1 Divietural 5 Panding (Month, Dey Year) 2 Accident investigation	Injury Work? M 1 Yes 2 No		
up the mosphal or Americans of Americans of Americans of the Functional Director: After the completely filled in by the funers of the funeral	3 Suicide 6 Could not be determined 28e. Plece of Injury - At hor		8f. Location (Street end Number or Rurel Ro	ute Number,
Dir.	4 Homicide building, etc. (Specify,		City or Town, Stete)	
Series O	29a. Certifler 1 Certifying Physician: To the best of my know	viedge, death occurred at the time, date and piece, at	nd due to the cause(s) and menner as eleter	
Fun Stely	(Check only 2 Medical Examiner: On the basis of examinations)	ion end/or investigation, in my opinion, death occurre	d at the time, dete end place, and due to the	cause(s)
within a respiral or when within 24 hours about To the Funeral Director: completely filled in by the Medical Certifical	250. Signature and this of certifier.	29c. License number	29d. Date signed (Month, Dey,	Year)
8 7 8	1	00 2111	8/19/00	· out
1	Haan, MS	84244	0/19/00	
0/	30. Name and address of person who completed ceuse of deeth (Item	23e) (Type, Print)	2-0 1/22-10	
V	UMAN HOLOMS, M. J. C/D	maryland (ren	Kal Mispital	
State	31. Date filed (Month, Dey, Year) 32. Registrer's Signati	MITO DE STORES		
Registrar	AUG 2 5 2000			



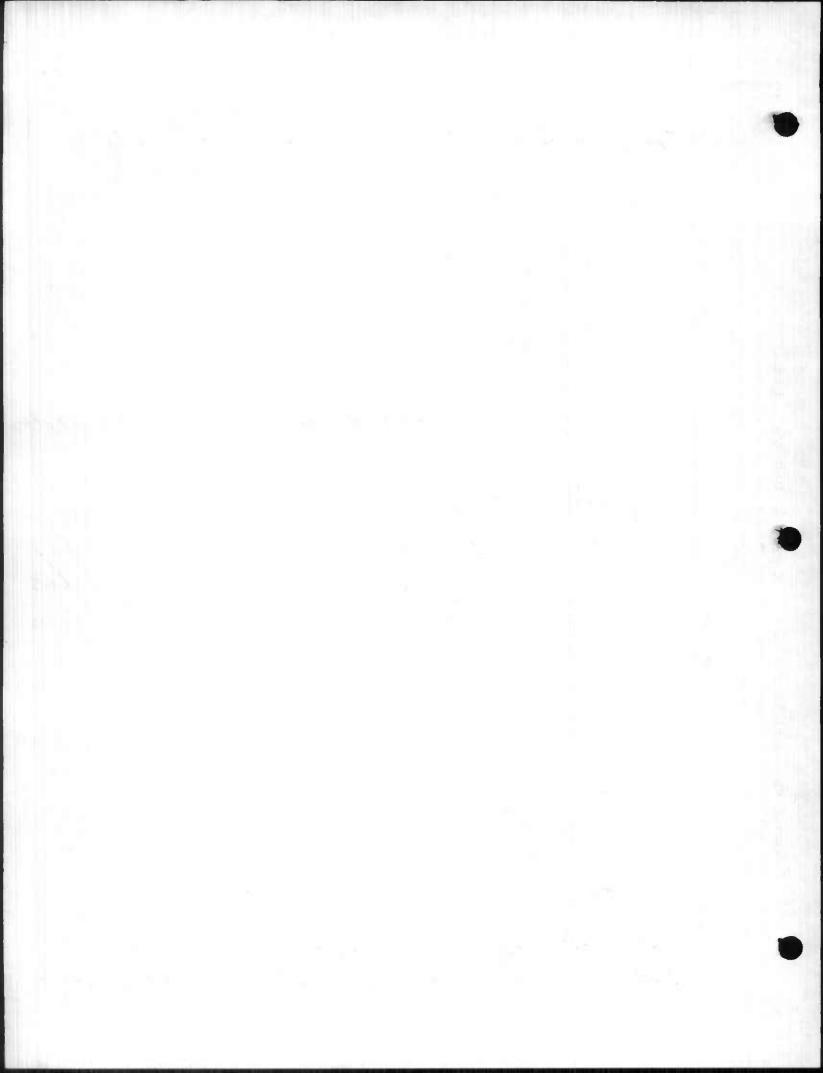
Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

hysician	1. Decedent's Neme (First, Middle, Last))LEM	4 1/		2. Date of Dee Month	th Dey	3. Time of Death
nysician /Medical	VVI == 1711/-) 1.				Aug	13 2	2000 10.25 47
Examiner	4a Facility Name (If not institution, give street and number)			b. City, Town, or Lo		4c. County	of Death
	Bon Secour Hospital 5. Social Security Number 6. Sex 7. Ag	e (In yrs. lest birthday) If Under 1 Yeer	Baltimore		n/a	9 Birtholace (State or Foreign
rector	212-05-5468	90 Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Day July 14	, Year) , 1910	9. Birthplace (State or Foreign Country) Maryland
dan "	10a. Stete 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
or 28a-1 a be notified Director	Maryland Baltimore	Catonsvi					
	10a. Street and Number 5723 Edmondson Avenue		10f. Zip Code 21228			log. Citizen of W United S	
Examiner must by Funeral	11. Mentel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Armed Forces? 1 Armed Forces? 1 Armed Forces? 1 Armed Forces? 1 Armed Forces?		Wes Decedent of H It Yes, specify Cubs 1 ☐ Yes 2 ☑ No	ispenic Origin? (Spe n, Mexican, Puerto i Specify:	cify Yes or No-	14. Race	- American Indien, k, White, etc.
t, the Medical	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 1)	5+)	edent's Usuel Occup e kind of work done DO NOT use retired it manage	etion during most of worki f)	ng	16b. Kind of Bu	
Be C	17. Father's Neme (First, Middle, Last)	CICU	ic manage	18. Mother's Neme	(First, Middle,	0	
To B	unknown			Sara (ı	nknown))	
-	19e. Informent's Neme/Relationship (Type, Print)		ling Address (Street	and Number or Rura	Route Numbe	r, City or Town,	State, Zip Code)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Gertrude M. Coleman - wife			n Avenue,			laryland 21228
ry or of	20e. Method of Disposition 1 ABurlel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)		emetory or other piece Park Cemet		26/00		city or Town, Stete
any inju	21. Signeture of Funeral Service Licensee			ss of Fecility Hubb 4107	ard Fur Wilker		ome, Inc.
	23a. Pert 1. Enter the disease, or complications that cause shock, or heert feiture. List only one cause on each li	d the deeth. Do not en	nter the mode of dyin				Approximate Interval Between
cian lical liner	Immediata Cause (Final disease or condition resulting in death)		SMA popularies of):				Onset and Deeth Welk
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury the Initioted events resulting in death) Last	Due to (or es a conse	equence of):				
ed for use a	Pert fl. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giv	en in Pert I.	23b. Dld t	obacco uae cor	ntribute to the cause of death?
be detached by Physic	Arterio Aclerotic	cardiova	ascular	discus	101	rea 20KNo	3 Probably 4 Unknown
2 should	Abdominal aou	tic an	eurys	M_	24e. Wes	en eutopsy med?	24b. Wera autopsy tindings aveilable prior to completion of cause of death?
rector, page					101	es 21 No	1 ☐ Yes 2 7 No
Be	25. Was case referred to medical examiner?		Oth	26. Place of Deeth			
ig i	1 ☐ Yes 2 ☒ No Hospitel: 1 ☒ Inpatii 27. Menner of Deeth 28a. Dete of Inju		ent 3LI DOA	4 Li Nursing Ho		ence 6 Other	
d in by the funer certification	1 Neturel 5 Pending (Month, De 2 Accident Investigation	y Year) 280. Time	Wor	yat k? Yes 2□No	Lou. Describe I	on injury occurr	
Certification:	3 Suicide 6 Could not be	iury - At home, ferm, s c. (Specify)	treet, tactory, office		28t. Location (S City or Tow		er or Rurel Route Number,
Medical Cert	29a. Certifier (Check only one) Certifying Physician: To the best of and menner st	f examinetion and/or i	th occurred et the tir nvestigetion, in my o	ne, dete and place, a pinion, deeth occurr	and due to the ded at the time, d	cause(s) and me dete and piece, a	nner aa stated. and due to the cause(s)
completely filled Medical Ce	29b. Signature and little of partition	F/11/1/	29c. Licens	e number		29d. Dete signed	(Month, Day, Year)
	Markaran Ko		02			Aug	23, 2000 E. MO 21229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Month Day Year

		1 Decedents No.	ma /First Middle I	aetl		CE	ertificate d	Dealli		Reg. No.	0 20	Theres
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/Medic			A. CUNN	INGHAM ive street and number	herl			Ab City Town o	Aug r Location of Deet		y of Death	; 15 P.
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neral		5. Social Security			. Age (In yrs.	lest birthday	If Under 1 Ye		s. 8. Date of Bir		9. Birthplace	(State or Fi
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1		10a. State	10b. County		10c. Ci	ity, Town or L	ocation					nside City L
notified at	ctor	MD	Baltim	ore	Bal	timor	е				1	☐ Yes 🔏
1 P	Director	10e. Street end N	umber				10f. Zlp Cod			10g. Citizen of	What Country?	
1	rai		STON AVE				2122					
natural, or lette solo of sold and	Funeral	11. Marital Status	rrled 2 Married	12. Was Deced	es?	J,S. 13	If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No rto Rican, etc.))- 14. Ra	ce - American In ack, White, etc.	dian,
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2 6	П		Name/Relationship			19b. Mai	ling Address (Str	eet and Number or F	/	er, City or Town	n, State, Zip Code	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: #20 PER F.H. G786 8-25-00 WR. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death 82 raw Ford 23 00 redorick 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) n/a Baltim Wa Maryland NIVERSITY 8. Date of Birth (Moeth, Day (Year) Birthplace (State or Foreign Country) 15 M 20 F Hours Min 212-59-2429 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 625 21222 main 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) n/a College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DO rederick 10 Ke Craw Ford 19a. Informant's Name/Relationship (Type, Print) father 19b. Mailing Address (Street and Number or Rural Route Number, City Frederick & Nickell Crawford 625 Maine Street Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e Method of Disposition 2 Cramation 3 Removel from State 4 Donation 5 Other (Specify Metro Crematory Baltimore, Md. Aug. 24 21. Signature of Funeral S 22. Name end Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 ٤ ns that cased the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Between Onset and Death Isolemic Enephalitis Immediate Causa (Final disease or condition rasulting in death) Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably W Unknown 24b. Were autopsy findings 24a. Was an autopsy available prior to completion of cause of death? 1 ☐ Yes W No 1 Yes 2 No 25. Was case referred to medical 26. Placa of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show

Funeral Director

by

Completed

traumatic event, the Medical Examiner must be notified at

then

with the Meryland

filed within 72 hours after deeth

Pages 1 and 2 should be nent of Health end Mentel is marked of

permit. Pages 1 and 2 to Department of Health er Important: If item 27 is any injury or other treuence.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.

Physician/Medicai Examiner Be Completed by 0 Medicai Certification:

that the deeth certificate be asscuted The law requires or Attending Physician: after deeth. ersi Director: After thi filled in by the funeral

To the Hospital within 24 hours a within 24 hours at ... To the Funeral Completely filled

DHMH 16 Rev 6/95

State Registrar

31. Date tiled (Month, Day, Year) AUG 5

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicida

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

o completed cause of death (Itam 23a) (Typa, Print)

32. Registrar's Signature 2000

Hospital:

5 Pending investigation

6 Could not be

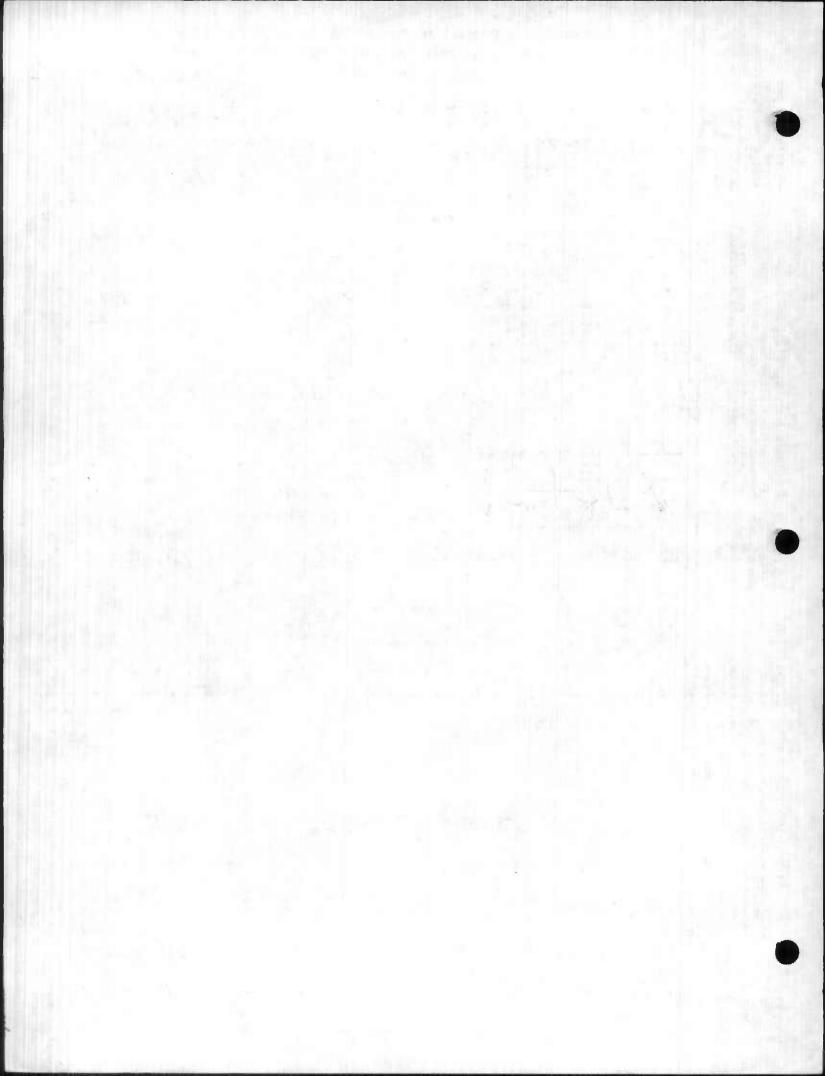
Inpatient 2 ER/Outpatient 3 DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work?

1 Yes

2 - No



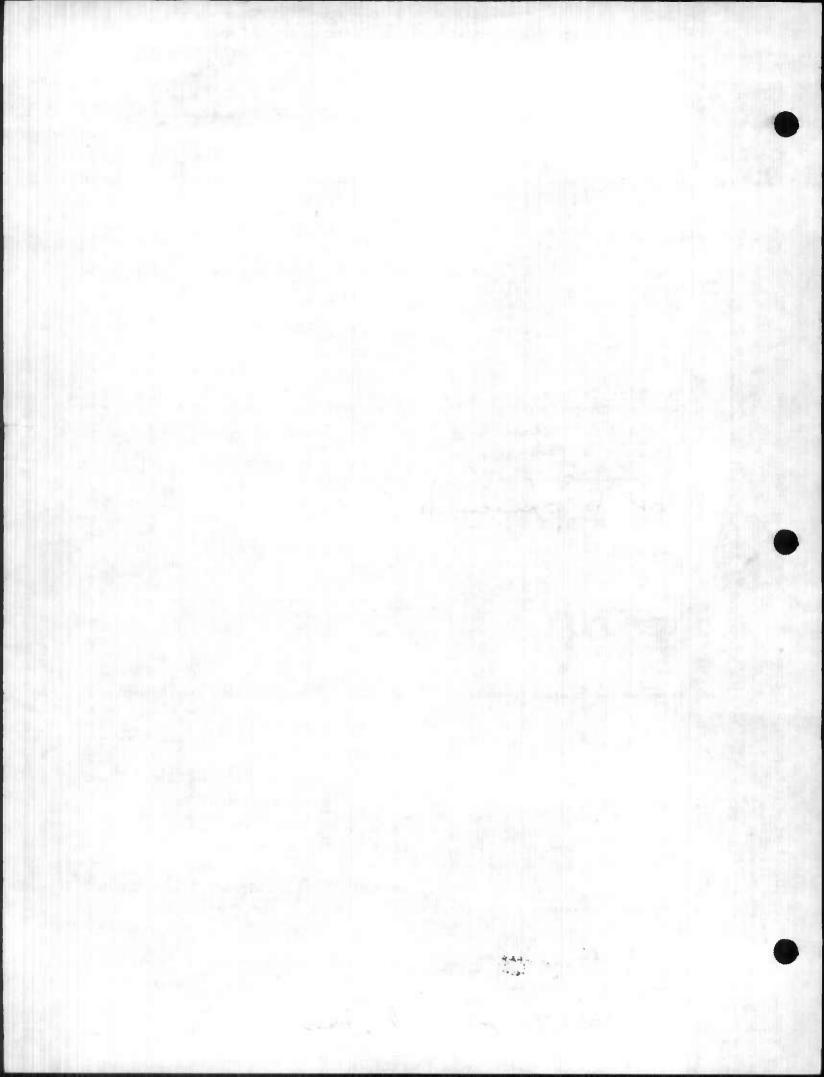
THEODORE COLBERT Jr. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Name (First, Middle, La	ist)		Pepartment ER MEO Certificate			2.1	Date of Death		Vec	3. Time of Death
Physician /Medical	Theodore			Col	ber	t Jr	-	Month UGUST	Day 21, 20	Year	03:07 A.M.
Examiner	4a Facility Name (If not institution, gives 500 BRICE STRE				4	b. City, Tow BAJJ	n, or Location		4c. County	of Death	
uneral rector	5. Social Security Number 6. S 219-50-1339 Usuat Residence of Decedent	IMM 2□F	(In yrs. last birt	thday) If Under Months Yrs.	1 Year Days	If Under 2- Hours	4 Hrs. 8. 0 Min. 0	Date of Birth Month, Day,	Year) 47		place (State or Foreign ntry) • V •
stat or	10a. Stete 10b. County		10c. City, Town		7, 1			18.			10d. Inside City Limits 1X□X'es 2□ No
or items 23a or 23a-f show miner must be notified at Funeral Director	MD NA 10e. Street and Number		Balti	101. Zip	Code			10	g. Citizen of V	Vhat Cou	ntry?
unt be	3842 Twin Lake	es Ct.			21	1244			U.S	. A.	
taminer m	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? **Eves 2 \sum No If Yes, Give Yeer or Dates:		13. Was Decedif Yes, spec		ispanic Origi an, Mexican, Specify:	n? (Specify Puerto Rica	Yes or No- n, etc.)		ck, White,	
		ducation	16a.	Decedent's Usua	l Occup	ation		10	6b. Kind of Bu		ack
Completed	(Specify only highest gra Elementary/Secondery (0-12) 12th grade	College (1-4or 5+)		(Give kind of work life. DO NOT us Special	e retired	1)	of working		N.A.S	. A.	
Be	17. Fether's Name (First, Middle, Last					18. Mother	s Name (Fil	st, Middle, Mi	aiden Sumem	ne)	
10	Theodore Colbe	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	19h	. Mailing Address	/Stroot			shing		State 7i	n Code)
	Shirlene Colbe	ert-Wife	20b. Place of cemeter	842 Twi Disposition (Nemry, crematory or of	n I	lakes	Ct,	Balti ate 2	more Oc. Location -	Md City or T	21244
any injury once.	21. Signature of Funeral Service Dee	nsee	1	22. Name and March	Addres	ss of Facility					
cal	23a. Fartt. Enter the disease, or cut shock or heart failure. List one immediate Ceuse (Final disease or condition resulting in death).	plications that caused the one cause on each line.		4300 W	Vaba e of dyin	ash A	ve, F ardiac or res	spiratory arres	nore M	1d	21215 Approximate Intervel Between Onset and Death
al er	immediate Ceuse (Final	8.	ACUT	4300 M	Vaba e of dyin	ash A	ve, F ardiac or res	spiratory arres	nore M	ld .	Approximate Intervel Between
dical Examiner	Immediate Ceuse (Final	b	ACUT	4300 M not enter the mode E NARCO	Vaba e of dyin	ash A	ve, F ardiac or res	spiratory arres	nore M	1d	Approximate Intervel Between
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State Registrar 31. Date filed (Month, Day, Year) AUG 2 5 2000

Dennis J Chute, mo 32. Registal's Signature

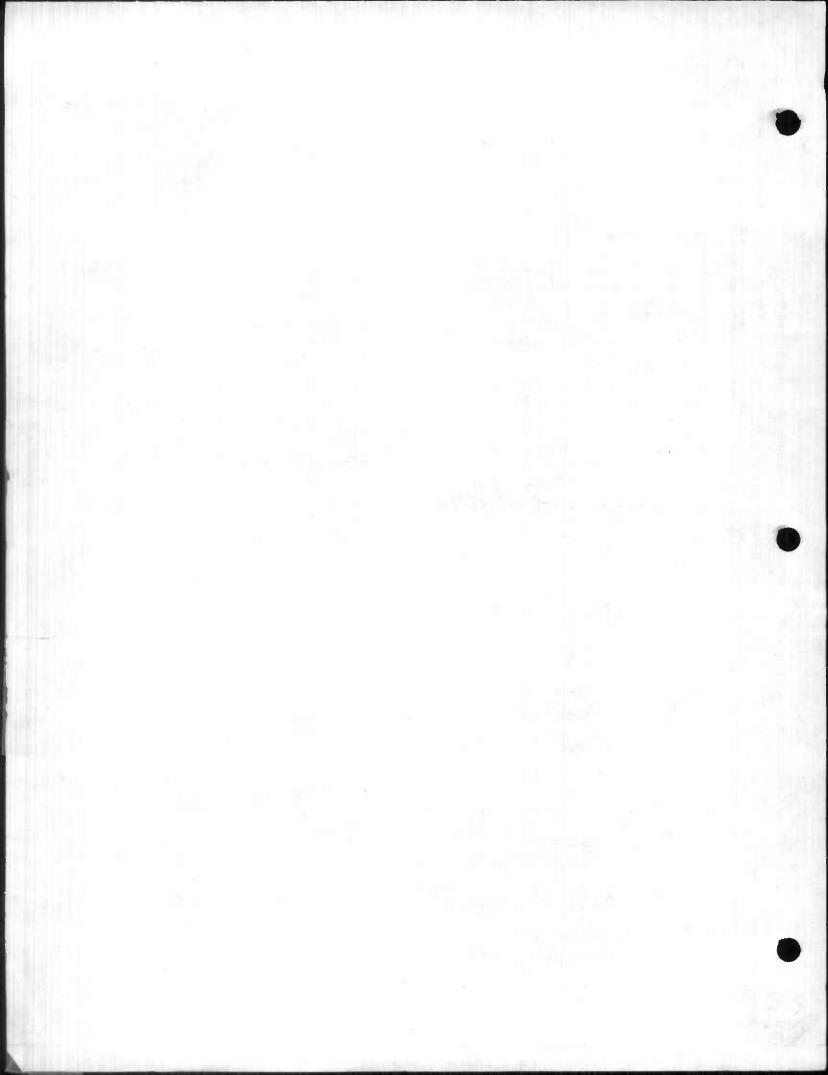
111 Penn Street, Baltimore, Maryland 21201



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State of Maryland / Department of Health and Mental Hygiene 00 26994

				Ce	nificat	e or	Death			Reg. No.		
Blanch	me (First, Middle, L	roll							2. Date of Do Month AUGUS	Day 22,	Year 200	
iner 4a Facility Name	(If not institution, g					- 4	4b. City, To	wn, or Lo	ocation of Deal	th 4c. C	ounty of Dea	ith
Berlin	Nursing	& Rehal	oilitat:	ion Cen	ter		Ber.	lin		Wo	rcest	er
5. Social Security	Number 6.	Sex	7. Age (In yrs	. last birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9. Bi	rthplace (State or Foreign
578-44-	7374	1□M 2⊠F	100	Yrs.	Months	Days	riours	Peter I.	Oct. 6	, 189	9 V:	irginia
Usual Residence	7											
10a. Stafa	10b. County			ity, Town or Lo								10d. Inside City Limits
DE	Sussex		Se	elbyvil	.le							1 ☐ Yes XIX No
10e. Street and N	lumber				10f. Zig	Code		-		10g. Citize	on of What C	ountry?
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11. Merital Status			cedent Ever in I	15 13	Was Doco			inin? (Sn	ecify Yes or N			erican Indien.
	rried 2 Married	Armed F	orces?	3,0.	If Yes, spe	city Cuba	an, Mexicar	n, Puerto	Rican, etc.)		Black, Whi	
	4 Divorced	If Yes, G	IVO		1 Ves	2X No	Specify:			S	pecify:	White
342 WIGOWEG			Dates.	40 0	4 4 11	10	140			400 16		
(Sp	15. Decedent's I ecity only highest g)	16a. Dece (Giva	kind of wo	nk done	lation during mos d)	t of work	ing	16b. Kind	of Business	s/Industry
Elementary/Se	condary (0-12)	College	(1-4or 5+)			se retired	3)					
5				Homem	aker						n Home	9
	e (First, Middle, Las								a (First, Middle	e, Maiden Si	umame)	
Tunis A	gustas Qu	uackenbu	ısh				Co	ora V	Walker			
19a. Informant's	Name/Relationship	(Type, Print)		19b. Maili	ng Address	s (Street	and Numbe	er or Run	al Route Numb	er, City or	Town, State,	Zip Code)
Delois	C. Steven	ns (Daud	hter)	59 S	ea Gu	111	Road,	Sell	oyville	, DE	19975	
20a, Method of D			20b.	Place of Dispo	sition (Na	me of		1	Date			Town, Stete
*XXBurial	2 Cremation 3		State	cometary, crea					08/26			
	5 Other (Spec			edar Hi			-		2000	Sult	land,	MID
21. Signature of	Funeral Service Lice	ensee	1/	22	2. Name ar	d Addre	ss of Facility	eral	Home,	P.A.		
7	111.0	(1)	Kill	0					e, Anna		MD :	21401
23a. Part1. Enta	the disease, or contact failure. List only	mplications that	caused the dea	th. Do not ent							,	Approximate
shock, or h	eart failure. List onl											Intervel Batween Onset and Deeth
Immediate Caus	/Final	0.	Perioa	0	A.	0	0.		0	1		
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l resulting in obati	,			or as a consec								
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Sequentially list if any, leading to cause. Enter Un Cause (Disease	immediata derlying											
that initiated ever	NS	C	Due to (or as a conseq	mence of):							
resulting in death) Last		200101	07 40 4 0011000	1001100 017.							
		I d										
Part It. Other sig	ificant conditions	contributing to	death but not re-	sulting in the u	nderlying o	ausa giv	en in Part t	t.	23b. Did	tobacco us	se contribut	te to the cause of death
Cas	ouleak	2 8/	une	Sen	-5				1□	Yes 20	No 3□1	Probably 4 Unknow
0		(V	110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				-				
(in	1-11-10		"Ka	100	-					s an autops; ormed?	y 24b	. Were autopsy findings available prior to
Corc		- 1	-	~	,			_	, p			completion of causa of death?
									40	Van of	Ma	1 DVac office
									10	Yes 2 M	NO	1 ☐ Yas 2 No
25. Wes case ref examiner?	arred to medical	Manakah				04		of Deat	h (Check only	ona)		
1 Yes 2	ð No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 D	OA Oth	16r: 4 % Nu	ursing Ho	me 5□Res	idence 6	Other (Sp	ecity)
27. Manner of De 1 W Natural	ath 5 ☐ Pending	28a. Data (Mo	of Injury oth, Day Year)	28b. Time o	f 2	28c. Injur Wor	y at k?		28d. Describe	how injury	occurred	
2 Accident	investigation		,	,,	М		Yes 2□	No				
3 Suicide	6 ☐ Could not determine	d 288. Plac	e of Injury - At h	nome, ferm, str	reet, factor	y, office					Number or f	Rural Route Number,
4 Homicide	Octomino	buik	ting, etc. (Speci	ify)					City or To	wn, State)		
20a Cartifica	450-444	Acotologo To the										
29a. Certifier (Check only	1DKCertifying P 2 Medical Exa	uniner: On the I	basis of examina	owledge, death ation and/or in	vestigation	at the tin	ne, date an pinion, dea	ith occurr	and dua to the ed at the time	cause(s) a , data and p	nd manner o lace, and du	es stated. ue to the cause(s)
ome)		and ma	nner stated.									
29b. Signature ar	d title of certifier	70	2.	0	29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)
1/20	anne.	14. 1	ulla	04	217	72	950	5		8-	22.	2000
80. Name and ad	of person who	completed car	se of death fits	m 23e) (Type	Print)		170	-	410-341			
						Line	ADEC				/1011	1/0 21001
31. Data filed (M		BELLO			02 0	MIN	MBCK	KY	NK.12	ALISE	uky,	MD 21801
_			Registrar's Sign	ature								
A	JG 25 20	nn	24	. 1.	P							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#10c,d,e,f G786 8/25/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death COHEN ABRAHAM

Physician	
/Medical	
Examiner	

4a Facility Name (If not institution, give street and number) NORTHWEST

Day Year 22 2000 AUGUST

3. Tima of Death

Funeral Director

with the Maryland must be notified at

Physician /Medical Examiner

The law requires that the death certificate be executed this certificate has Attanding Physician: director, Certification: To funeral To the Hospital or Attandit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. Medical

Box 68760.

Division of Vital Records, P.O.

Usual Residence of Decedent 10a. Stata 10b. County BALTIMORE MD Funeral Director 10e. Street and Number 2500 W. Belvedere Ave #805 9715 BRANCHLEIGH ROAD 11. Marital Status 1 Never Married 2 Married by 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 17. Father's Name (First, Middle, Last) LOUIS 19a. Informant's Name/Relationship (Type, Print) CHARLES RAPPA / NEPHEW 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses roce Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed 25. Was case referred to medical examiner? 8 1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 (2 Natural

4b. City, Town, or Location of Death 4c. County of Death MANDAUSTOWN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1XM 2□ F 217-16-8543 RUSSIA 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No RANDALLSTOWN Baltimore 10f. Zip Code 10g. Citizen of What Country? 21215 -21133 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 X No Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry FOREMAN FISH 18. Mother's Nama (First, Middle, Maiden Surname) CCHEN ANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4305 GLENARM AVE. - BALTIMORE, MD 21206 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stata HAR ZION TIFERETH ISRAEL 8/24/00 ROSEDALE, MD 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batw Onset and Death CARCINOMA OF URINARY BLADDER Due to (or as a consequence of): Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

24a. Was an autopsy performed?

24b. Wera autopsy findings aveilable prior to completion of cause of death?

1 Yas 2 No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

1 Yas 2 No

5 Pending investigation

6 Could not be

PInpatient 2□ ER/Outpatient 3□ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

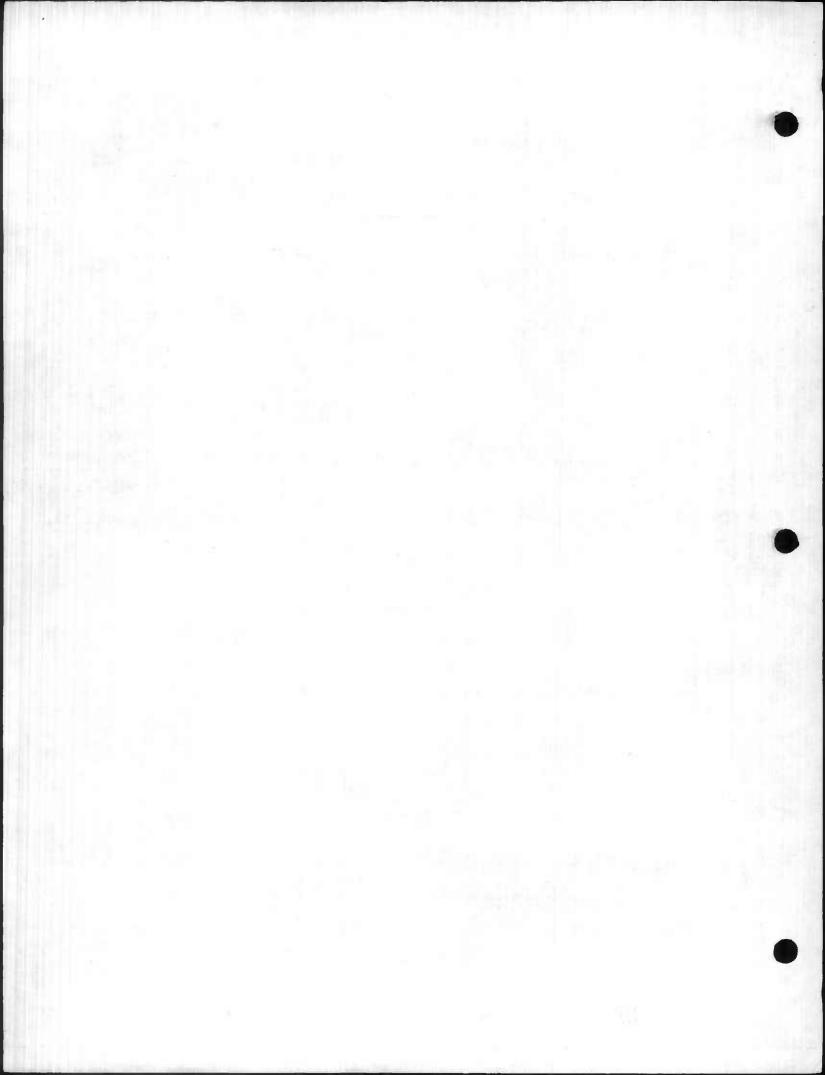
29d. Date signed (Month, Day, Year) AUGUST 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NHC BALTO. JUD 211 23 MAVI

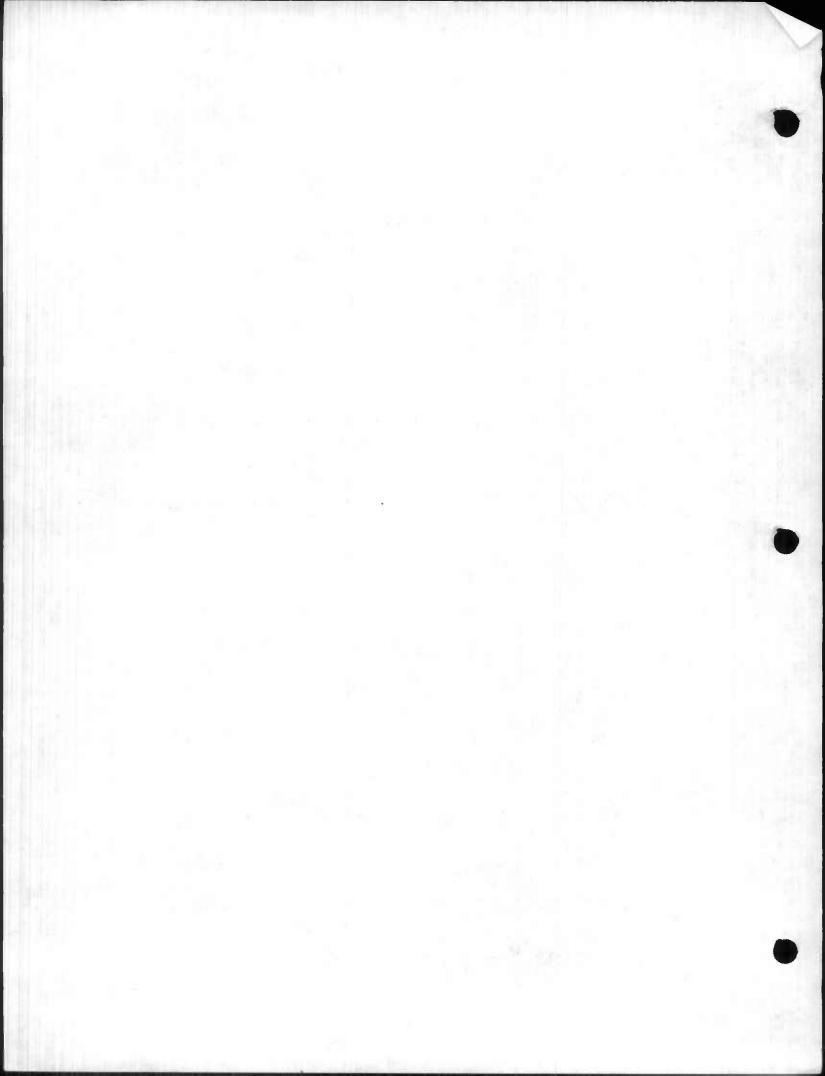
Registrar

31. Data filed (Month, Day, Year) AUG 2 5 2000 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

						4	Certifica	ate of	Death			Reg. No.	0 2	-0330
Physicia	_	Decedent's Name (First, Mide	die, Last)								2. Dete of De Month	Day	Year	3. Time of Death
/Medic	al	SAMUEL					COHEN 4b. City, Town, or Lo				August			18:04
Examin	er	4a Facility Neme (If not institution Sinai Hospit			COLOR COLOR									
Funeral		5. Social Security Number	6. Sex					der 1 Yeer				M/A f Birth D, Day, Year) 9. Birthplace (State of Country)		
Director		043-05-0600	15	M 2□ F	88		rs. Month	ns Days	Hours	Min.	AUG .			intry) MD
2 .		Usual Residence of Decedent 10a. State 10b. Count	he		100	City Town	or Location							10d. tnside City Lim
f show	5	MD 100. Court	N/A	\	100		TIMORE							1 X Yes 2 □ N
28a- notifi	Director	10e. Street and Number	LV/F	7		DAL		Zip Code				10g. Citizen o	f What Cou	intry?
Se of all	0	7218 PARK HEI	GHTS	AVEN	UE				212	208		U.	S.A.	
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atura ical E		15. Decede	ent'a Educ	cation		16a.	Decedent's U	sual Occup	oation	A m A committee		16b. Kind of	Business/Ir	ndustry
Med 'n	Completed	(Specify only high Elementery/Secondery (0-12)	7		(1-4or 5+)		(Give kind of life. DO NO?	work done Tuse retire	dunng mos	t or work	ing			
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ndal H	Be C	17. Father'a Name (First, Middle JACOB	e, Last)			COH	IFN		18. Mothe		e (FIFSI, MIDDE	, Meiden Surne		EL DEC
mark mark	2	19a. Informant's Name/Ralation	nship (Tv	pe. Print)	10.21			ass (Street			al Route Num!	per, City or Tow		ELDES
27 is 27 is r trau		ARLENE FISHKI			HTER		ll LIC					MORE, M		
Hem Hem		20a. Method of Disposition		-1.		Ob. Place of cameren	Disposition (/	Neme of or other ple	ce)		Date	20c. Location	n - City or T	own, State
ant: If		1 ☑ Buriat 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (emoval fron		(ANSHE				MIAI	8/24/0	O BAL	TIMOR	E, MD
epart sport ny inj		21. Signature of Funeral Service	e License	90	110		22. Name	and Addre	ess of Facili	ty	SOL L	EVINSON	I & BR	OS., INC.
88202		Acew 1	11/	W	ull		8900	REIST	TERSTO	WN F		PIKESVI		MD 21208
		23a. Part 1. Entar the disease, of ahock, or heart failure. Lis	or complie st only on	cations that ne ceuse on	caused the cach line.	death. Do n	ot enter tha m	noda of dyi	ng, such as	cardiac	or respiratory	errest,	i	Approximate Intarval Batween
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 0.8 Month **Physician** Michael 23^{ey} W. Cheek 2000 4:45 pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 1511 Light Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 15 M 2□ F Months Yrs. 216-66-9501 Director 26,1955 Nov. MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, fnside City Limits or items 23s or 28s-f show the Medical Examiner must be notified at 15 Yes 2 No Md. N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1511 Light Street 21212 USA Funeral 14. Reca - American Indien, 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 200No Aq 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 VTS College (1-4or 5+) 5 yrs yrs Chef Amtrak 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) t and Mental to manked of ahould be Lester Gene Cheek Mildred A. Barrow Jernit. Pages 1 and 2 am Department of Health Important if the any injury -19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jackie Berry Friend 1511 Light St. Baltimore, Md. 21212 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) Aug 26 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donetton 5 Other (Specify) 2000 Holly Hill Cemetery Middle River, Md. 22. Neme end Address of Fecility 21. Signature of Fil Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 Approximate Intervel Between Onset and Deeth at caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. hysician /Medical Immediate Ceuse (Fine Longestine disaasa or condition resulting in death) Examiner Due to (or es a consequença of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or es a consequence of): use as the burial-trar Box 68760. thet Initiated events resulting in deeth) Lest Due to (or es a consequenca of): P.O. | Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Medical Certification: To Be Completed by page 2 should be 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy 1□ Yes 25 No 1 ☐ Yes 2 No or Attending Physician: the funeral director, 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Mesidenca 8 Other (Specify) 1 Yes ST No After this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation 1 Matural s after death. 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Hospital 1 Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Description Headical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 8/24/00 35243 6

DHMH 16 Rev 6/95

State

Registrar

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32. Registrer's Signeture

Deper

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

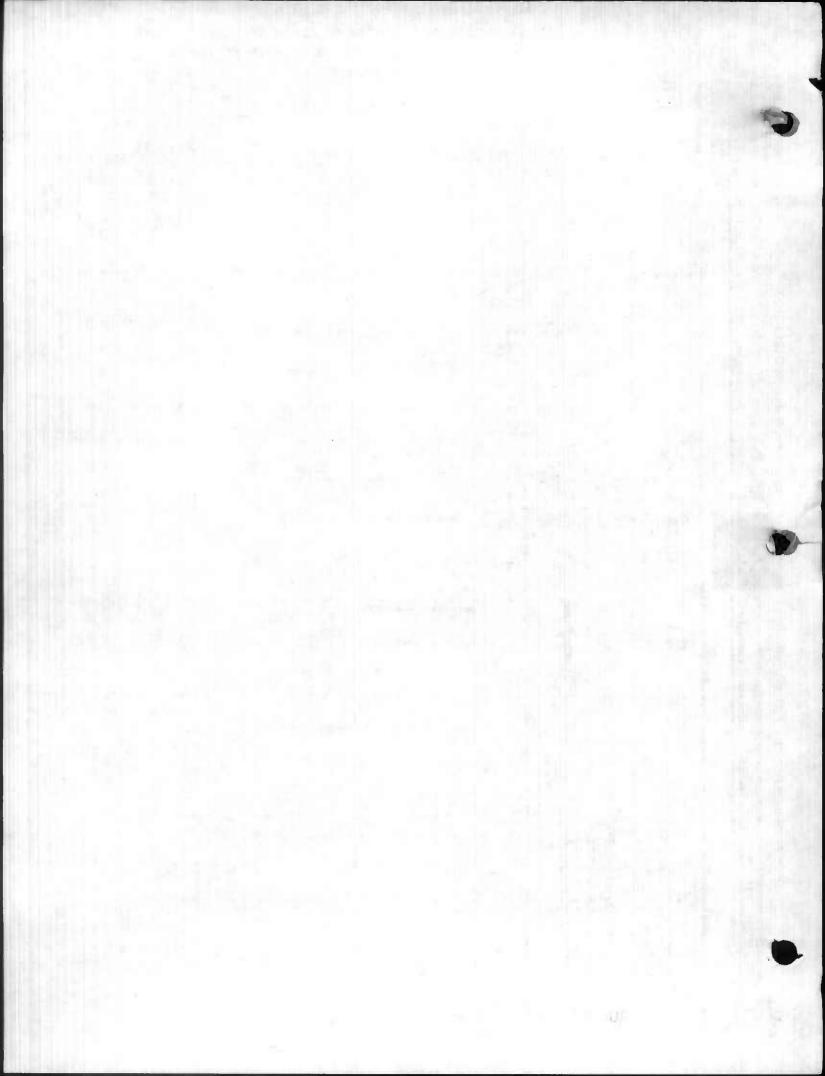
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31. Dete filed (Month, Dey, Year) AUG 25



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item #5 per fh g787 9/5/00 ah Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dafe of Death 3. Time of Death - 22, 2000 1007AM **Physician** Duvall Charlene /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number 4b. City. Town, or Location of Death Examiner 105pital etemore varyland reneral If Under 1 Year If Under 24 Hrs. 7. Age (Irl yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1 M 20 F Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Name 23s or 28s-f show the Medical Examiner must be notified at XXYes 2 No Baltimore MD NA Director 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? USA 21201 126 N. Poppleton Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedanf Evar in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Yes & No 1 Nevar Married 2 Married b Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa refired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 11th Grade Laborer various trades 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Mental 8 Atlean Bryant William Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) . 126 N. Poppleton Street Baltimore, MD. Atlean Bryant Important: If item 27. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate Pages Burial 2 Cremation 3 Removal from State Garrison Forest VA Cem. 08-26-2000 Owings Mills 22. Name and Addrass of Facility 21. Signatura of Funaral Sarvice Licensee Baltimore, Maryland 21202 lad WM.C. March FH 1101 E. North Avenue Warre 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart fallure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumonia Examiner Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last as the burial-tran Box 68760, Kenal Dua to (or as a consequence of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of geeth? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy this certificate has been 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case rafarred to medicel 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□ Yes 2DNo 1 Dinpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 1 DNatural 5 Pending Injury investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physician: after death. eral Director; After this certific filled in by the funeral director, Division

io the Hospital within 24 hours a To the Funeral C completaly filled

State Registrar

31. Date filed (Month, Day, Year)

29a. Cartifier

29b. Signature and title of certifie

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29c. Licanse number

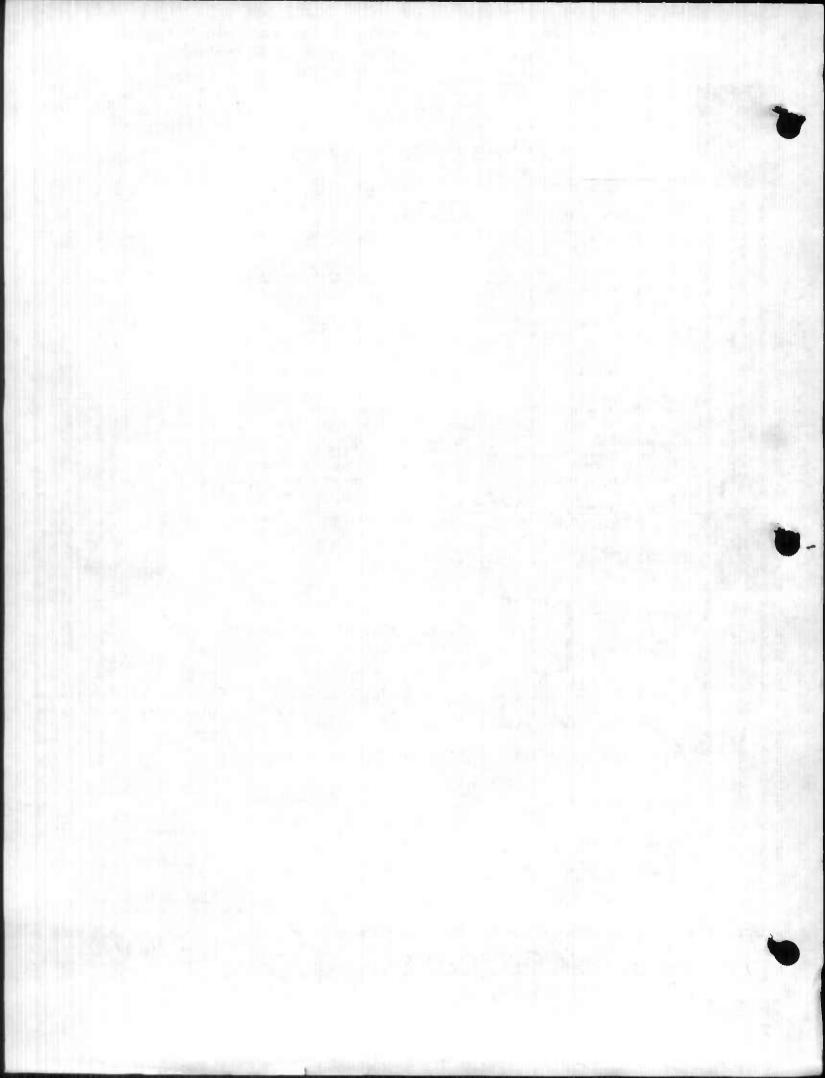
115 Certifying Physician: To the best of my knowledge, dasth occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

8/22/00

30. Name and address of person who completed ceuse of death, (tam 23a) (Type, Print)

25

32. Registrar's Signature



Registrar

Maryland

altimore,

68760.

Box (

P.O.

Records,

Vital

of

Division

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DHMH 16 Rev 6/95

State

29b. Signatura and titla of certiler

31. Data filed (Month, Day, Year) AUG 25

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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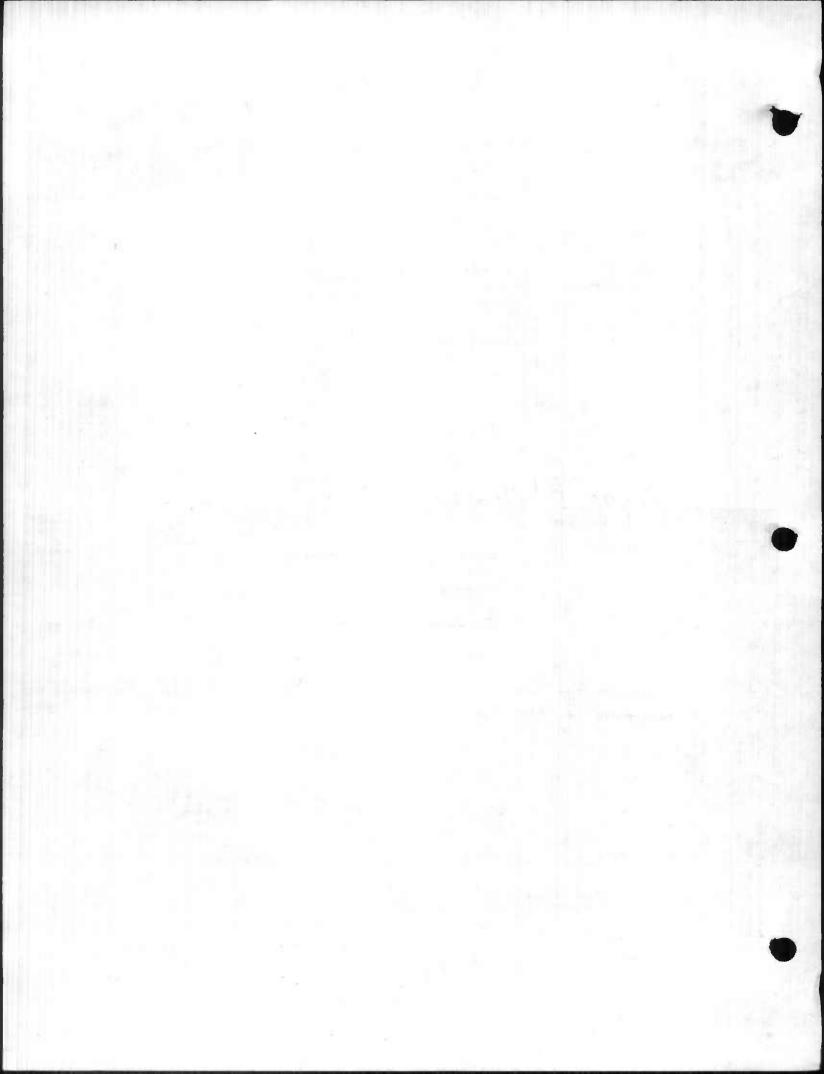
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29d. Data signed (Month, Day, Year)

8/25/2000



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		NORTHWEST HOSE	PITAL CENT	TER			RAN	DALLS	STOWN	BALTIN	MORE	
	Funeral		Sax 7. / 1 ☑ M 2 ☐ F	Aga (In yrs. I	last birthda Yrs	Months Da	ar If Under	24 Hrs. Min.	8. Data of Birth (Month, Day	Year)	9. Birthplac Country)	a (Stata or Foraign
	Director	212-01-2986 Usual Rasidance of Dacedant	- X	83	115				SEP.20	,1916		MD
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21215-0020	within 72 hours after death with the Maryland she "he "hear" or 18a-1 show the Medical Exercises must be notified at property or provided by Funeral Director	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedar Armed Forcas 1 X Yas 2 If Yas, Giva Yaar or Datas	s? □No AR	TIT	3. Was Decedent of If Yas, specify C			Rican, atc.)	Specify.	k, Whita, atc.	
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Maryland	and M and M armed	19e. Informant's Neme/Relationship	(Type, Print)		19b. M	ailing Addrass (Str	eet and Numb	er or Rura	l Route Numbe	r, City or Town,	Stete, Zip Co	ode)
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D) F	Physician /Medical	Immedieta Cause (Finel		00	0 101	1-		05				nset and Death
ı	Examiner	diseasa or condition resulting in death)	a			AL P	MICH	K 6			- 1	
	ام السالم			COR	CON	sequence of):	1RE	MSA	D1867	786	1	
1	eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions,	b			sequence of):	1					
,092	siclan a burial-	Sequantially list conditions, if any, leeding to Immadiata cause. Enter Underlying Cause (Diseasa or Injury	C									
	physis the i	that initiated avents resulting in death) Last		Due to (or	as a cons	sequence of):						
Вох	nding use a n		d									
Ď.	the death certifically the ettending physician/Med	Part II. Other significant conditions	contributing to death	but not rasu	iting in th	a underlying causa	given in Part	1	23b. Did to	obacco usa cor	ntribute to th	e causs of death?
۵.		CHP										oly 4 Unknown
Records,	been s should	Arria 7	Pibrilla	Teas					24a. Was a perfor	an autopsy med?	availa	autopsy findings bla prior to lation of cause ath?
	page								1 🗆 Y	as 2 No	1 🗆 Y	as 2 No
	entifica sctor.	25. Was casa rafarrad to medical axaminer?						a of Death	(Check only or	ne)		
50	rhis certific ral director.	1 Yas 2 No	Hospitet: 1 1 tnpa		ER/Outpa	tient 3LI DUA		7		enca 6 □Oth		
LO.	After funer funer	27. Mapmar of Death 1 Natural 5 Pending 2 Accident Invastigetic	28a. Date of tr (Month, L	Day Year)	28b. Tima Injur		njury at Work? 1 □ Yas 2 □		280. Describe h	ow injury occurr	ed	
Division of	to the hopping of Antondag Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Completely	2 Accident Invastigetic 3 Suicide 6 Could not I 4 Homloida detarmined	be 28a. Placa of I	Injury - At ho atc. (Specify	ma, ferm,	street, fectory, offi			28f. Location (S City or Tow	treet and Numb n, Steta)	er or Rural R	oute Number,
	filled Dames	29s. Certifier 1 Certifying P	hysician: To the bes	ot of my know	dadaa da	ath conwood at the	a time, data as	ad ataon.	and due to the	aver(a) and ma		
	n 24 hou n 24 hou ne Funer pletely fil		miner: On the basis and manner:	of examinat	ion and/or	r invastigation, in m	ny opinion, dea	ath occurre	ed at the time, o	lata and placa,	and dua to th	a cause(s)
	within To the	29b. Signatura and title of certifier	1 2			29c. Lic	ense number		- 2	29d. Date signed	d (Month, Da	y, Year)
		1054	- in	> au)	7)	16450	180		AU BUS	7 23	,2000
11	6	30. Name and address of person who	completed causa of	f deeth (Item	23a) (Ty	,	^					
		31. Data filed (Month, Dey, Yeer)	MPER	MIL	106	, - m	1)					
	State Registrar	AUG 2 5 20		strar's Signet	B	Spar	6					

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